Laura L. Baird, Psy.D.
267 William Street
Middletown, CT 06457
(860) 231-2208

Authorization to Release Information

Client's Name:_____

Client's Date of Birth:_____

The undersigned hereby authorizes:

Name and Telephone Number:_____

Address:_____

To disclose to Laura Baird, Psy.D., and for Dr. Baird to reciprocate, the following:

Information from records in his/her possession regarding history, physical examination, psychological and psychiatric evaluation, drug and/or other substance abuse evaluation, laboratory investigations, medical diagnoses including information regarding HIV status, psychiatric/psychological diagnosis and treatment, including all admission notes, treatment summary, and continuity of care plan; in short, any and all information which might be considered relevant to their psychological treatment.

The purpose of this release of information is the following:

___ Coordination and continuity of care
___ Obtaining authorization for payment of treatment
___ Legal representation
___ Other:_____

The release is for __ verbal OR ___ OR written OR ___ verbal and written information. This authorization to disclose information may be revoked by me at any time except to the extent that action has been take in reliance thereon. This consent, if not withdrawn, will remain in effect for one year from the date it is signed. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Signature of the Client:_____

Date:_____

Signature of the Client's Representative (if applicable):_____

Relation to Client:_____

Date:_____