Baker Neuropsychology
and Learning Center

Authorization to Request or Release Confidential Information

Client's Name _____ Date of Birth _____

Name of Parent/Guardian _____

I hereby authorize (circle specific provider): David Baker, Psy.D. Liza Baker, M.A.

to **request/release/exchange** information **from/to/with** the following individual, provider or institution. (Please specify direction of information exchange)

Name of Individual, Provider or Organization to receive or release information_____

Address _____

Telephone _____Fax _____

Information Requested (check all that apply):

School records: ☐ Medical records: ☐ Psychological/Neuropsychological testing: ☐

Treatment/progress notes: ☐ Educational testing ☐ Standardized testing: ☐

Specify requested materials:_____

The purpose for the release of these records is for evaluation and treatment planning. This authorization extends to the release of any drug and alcohol related information in the record. This authorization may be revoked by notifying Baker Neuropsychology and Learning Center in writing. A photocopy or facsimile transmission of this release shall be accepted as the original.

Unless otherwise indicated here (expires _____) this authorization expires 24 months from the date signed.

Any information released by this office to another individual or entity shall not be forwarded without written authorization and further consent by the patient or guardian.

I understand that I have the right to receive a copy of this authorization upon my request.

_____ _____

Signature of Client or Legal Representative Date

_____ _____

Baker Neuropsychology
and Learning Center

Witness Date