Linda L. Baley, LPC
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Authorization for Treatment and Release of Client Information

_____
Full Name (Please Print)

_____
Date of Birth

_____
Parent/Guardian/Managing Conservator's Name (Please Print/if same please note)

I authorize the release of or request access to the information specified below:

- ❑ **Diagnosis/prognosis**
- ❑ **Evaluation/Treatment Summary**
- ❑ **Case narrative and statements by others regarding behavior**
- ❑ **Psychological assessments results**
- ❑ **Additional information such as _____**

The above information may be released to/or accessed from:

_____
Name/Address/Phone number/Fax number

_____
Name/Address/Phone number/Fax number

_____
Name/Address/Phone number/Fax number

The information may be released in verbal and written form. This consent will remain in force until midnight _____ unless revoked in writing by the undersigned. This consent may be revoked in writing any time in the form of a notarized letter from the undersigned. If the consent is revoked in writing, it will not be retroactive. Linda L. Baley will not be held liable or accountable. This authorization is given freely, without reservation, inducement or coercion. By my signature below, I affirm that I am legally responsible for my counseling/treatment and to my knowledge no legal omissions have been made.

_____
Client or Client's Legal Representative **Date**

_____
Witness **Date**