Catreace Brown-Baker, MA, LPC, LPC/S
Thomas W. Mullins, MS, LPC (Independent)
Gabriel A. Baker, MA, LPC, NCC, CCMHC

Mental Health Providers with BAKERS Counseling Services, LLC

P.O. Box 961 Beaufort, SC 29901-0961
12 Fairfield Road, Suite B3 Beaufort, SC 29907
Phone: (843) 379-1003; Fax: (843) 379-0700

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **BAKERS Counseling Services, LLC** to release healthcare information of the patient named above TO and FROM:

Professional's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone Number _____ Office Fax Number _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of **my STD results, HIV/AIDS testing, whether negative or positive**, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding **drug and/or alcohol treatment** to the person(s) listed above. **This DOES NOT apply for Certified Addiction Counselor (CAC) because of the law (42 CFR Part 2). He/she cannot disclose alcohol and drug information.**

Patient Signature: _____ Date Signed: _____

Parent/Legal Guardian Signature: _____ Date Signed: _____

Printed Name of Patient/Parent/Legal Guardian: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.
CLIENT MUST SAY **IN WRITING** WHEN HE OR SHE **WANTS TO REVOKE** THIS RELEASE.