Diane Bauer, M.S., Registered Psychotherapist
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Consent for the Release of Confidential Information

I, _____ of
_____
(Name) (Address)

authorize Diane Bauer, Psychotherapist, to release information to and receive information from:

_____
____
(Name of person(s) or organization(s) to which disclosure is to be made)

for the following information:
_____
(Extent or nature of information disclosed)

for the following reason(s):
_____
(The purpose or need for disclosure)

I understand that my records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by submitting a written request and that this consent expires automatically as described below.

The date, event, or condition upon which this consent expires is:
_____

I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. Furthermore, I certify that I have the legal authority to authorize this release.

_____
Client Name (please print)

_____ _____
Client Signature (if required) Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist/Witness Date