Kessler Bickford, LCPC
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Easton MD 21601
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AUTHORIZATION FOR RELEASE OF PROTECTED HEATH CARE INFORMATION

I, ____ (print full name)
herby authorize Kessler Bickford, LCPC, to exchange, release or obtain private health care information pertinent to my treatment with:

Name ____

Type of Professional/School/Institution/Other ____________________________

Address ______________________________Phone __________________________

This information is requested for the purpose(s) of:
__Consultation
__Coordination of care
__Other (please describe): ____

I release Kessler Bickford from any legal liability resulting from the release of this information with the understanding that she will exercise reasonable professional standards. I understand that once protected heath information is disclosed, it may be disclosed by the recipient and may not be protected by privacy laws or regulations. In addition, I understand that as a part of the treatment of the identified client, family history information may be released. I understand that this authorization may be revoked by the client at any time except to the extent that the disclosure has already been made in reliance on the previously given authorization. To revoke this authorization, send written notification to this office. This consent expires 12 months from the date listed on this authorization. This form has been fully explained, and I certify that I understand its contents.

Client Signature ____

Print name ______________________________________ Date ______________