Jill C. Baird, Ph.D.
Constructive Alternatives, LLC
24300 Chagrin Blvd., Suite 309
Beachwood, OH 44122
Phone: (216) 223-7169

Authorization for Release of Confidential Information

I, _____, authorize Jill C. Baird, Ph.D./Constructive Alternatives, LLC to:

- ❑ release to
- ❑ obtain from
- ❑ exchange with

Name: _____
Address: _____
_____
_____
Phone: _____

the following information pertaining to myself *(please initial each that applies)*:

_____ Intake summary
_____ Progress notes
_____ Complete summary of therapy to date (including above info)
_____ Termination summary
_____ Dates of therapy attendance
_____ Verbal summary/discussion of therapy process/progress
_____ Psychological test/assessment results
_____ Medical/medication/hospital records
_____ Mental health evaluations
_____ Diagnoses
_____ Any info disclosed during couples therapy
_____ Other *(please be specific):* _____
_____ There are no restrictions on what info may be shared with the party named above.

I am requesting the release of this information for the following reasons:

___ At my request
___ At the request of _____
___ To coordinate treatment efforts
___ To facilitate current treatment by Dr. Baird
___ To facilitate a referral to_____
___ Other (please be specific):_____
_____

This authorization shall remain in effect until *(expiration date)* _____ or until *(fill in an event that relates to the individual or the purpose of the use or disclosure)* _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the therapist's office address. However, my revocation will not be effective to the extent that the therapist has already taken action in accordance with the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature Date