

FRANK BAIRD, LMFT

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Authorization for a Two-Way Release of Information Pursuant to the "Confidentiality of Medical Information Act"

Client Name: _____ Sex: F M

Birthdate: _____

I authorize Frank Baird, LMFT and

_____	_____
(Name or Title of Person)	(Agency Name)
_____	_____
(Address)	(City, State, Zip)
_____	_____
(Phone Number)	(Fax Number)

to release the following types of information to each other: Any information, verbal or
written, considered by Frank Baird to be helpful in our ongoing therapy.

This information will be used for: Therapeutic purposes.

This authorization shall remain valid until: cancelled in writing by the undersigned.

I have received a true copy of this signed authorization:

_____	_____
Signature	Date
_____	_____
Relationship to Client	Date

