

Ashley H. Buescher, MA, LPC, BCBA

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Authorization to Release Information

I, _____ authorize

Ashley H. Buescher, MA, LPC, BCBA
and

(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

- _____ All Health Care Information
Initials
- _____ Health Care Information or Opinions Relating to any or all of the
Initials following treatment(s) and, or conditions:
 - _____ 1) Psychiatric or Mental Health Information
Initials
 - _____ 2) Academic and Confidential School Information
Initials
 - _____ 3) Testing
Initials
 - _____ 4) Other _____
Initials

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

Patient Date

Parent or Legal Guardian Date

Witness Date