FREEDOM COUNSELING CENTER INC.

1901 Niles Ave, Ste 102
Saint Joseph, MI 49085
(269) 982-7200 Fax (269) 982-0202

PERMISSION FOR RELEASE OF INFORMATION

Purpose for the disclosure: To facilitate and coordinate evaluation and/or treatment services.

I, _____ hereby authorize

Freedom Counseling Center, inc.
(Doctor, Agency, etc.)

1901 Niles Ave. Suite 102 St. Joseph, MI 49085
(Address)

To disclose the following information to: _____

_____

Regarding (my name) _____

(My minor Child/Children) _____

Type of information to be released:

- ☐ Billing
- ☐ Testing/Evaluation
- ☐ Appointments
- ☐ Demographics
- ☐ Intake
- ☐ Progress Notes
- ☐ Attend Session
- ☐ Other (Specify) _____

I also authorize Freedom Counseling Center to, verbally or in writing, communicate to the above-named person or agency in behalf of my treatment or the treatment of my family.

_____ _____
Client Signature or Relative/Responsible party for client Date

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already acted in reliance on it. If not previously revoked, this consent will expire within one year.