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.
2155 Jackson Ave. Suite 1, Ann Arbor, MI 48108

To disclose the following information to: _____

_____

_____

My minor Child (if applicable)

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.

Occasionally it is necessary to be in contact with other treatment providers or other individuals to coordinate your care. If this is the case, insurance will not pay for this communication. Charges for all phone calls or electronic communication that is longer than 10 minutes at a percentage based on our hourly rate may occur. Signing below indicates that you consent and agree to be billed for these charges.

_____ _____

Client or Responsible Party Signature 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.