Freethought Counseling

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize _____
(Facility/Provider)

_____ to release
(Address)

_____
(State specific nature of information to be disclosed)

from the clinical record of_____ (_____)
(Name of client/recipient of mental health services) (Date of birth)

to Freethought Counseling LLC, PMB#260, 5760 S. 108th St., Hales Corners, WI 53130, e-mail counselor@freethoughtcounseling.com for the purposes of facilitating counseling/consultation, and/or conducting an evaluation.

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Freethought Counseling LLC. I understand that a revocation is not valid to the extent that Freethought Counseling has acted in reliance on such authorization. This authorization is valid until _____.
(Date)

A copy of this release shall have the same force and effect as the original.

_____
(Client Signature 18 yrs. or older) (Date)

_____ _____
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.