Spiritual Family Counseling, LLC.
33150 Schoolcraft RD, STE 102, Livonia, MI 48150
Office: 517-214-6531 Client: 313-389-6254
Fax: 844-829-4484
Email: spiritualfamilycounseling@outlook.com

AUTHORIZATION FOR RELEASE OF INFORMATION

This is an authorization to release and/or obtain information pertaining to my minor child or myself.

Patient name: _____ DOB: _____

I authorize Spiritual Family Counseling, LLC and/or its designee to: (circle applicable option/s)

EXCHANGE RECORDS WITH SEND RECORDS TO OBTAIN RECORDS FROM SHARE INFO WITH

Organization name: _____
Street address: _____
City, state, zip: _____
Phone: _____ Fax: _____
Email: _____
Purpose of disclosure: _____

I understand that I may revoke this consent by providing written notification to the designee. I may not revoke this consent in circumstances where Spiritual Family Counseling has taken certain actions prior to revocation.

My signature indicates that I know what information is being disclosed. I authorize disclosure of records including, but not limited to, the treatment of chemical dependency and/or substance or alcohol abuse to Spiritual Family Counseling for the purposes stated above. Treatment services are not dependent on my signing this release. My signature also means that I have read and understand this document.

Patient/Guardian signature: _____ Date: _____

Witness signature: _____ Date: _____