EDEN COUNSELING, LLC
(248) 602-0322

NAME: _____
DATE OF BIRTH: _____

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Patient Consent to Release/Exchange Information (to be completed by patient or parent/guardian)

I, _____, _____, authorize the exchange of information between
(Patient Name) (Date of Birth)
Eden Counseling, LLC and:

_____
Name

_____
Address City State Zip

_____
Telephone Number / Fax Number

To release/exchange information regarding: _____

_____

_____

_____

For the following purpose: _____

_____

_____

_____

I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. Information exchanged may include information on mental health care, HIV status, substance abuse care, diagnosis, treatment, and psychotherapy notes. The information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

_____ _____
Signature with Credentials Date