

Finding Freedom Now, LLC

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Finding Freedom Now, LLC and _____ to exchange any and all information pertinent to my condition.

By signing this consent to release information, I agree not to hold liable either party above if they discuss my case with each other.

I have been informed of the type of information being released, the benefits and disadvantages (if any), and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Patient Signature

Date

Parent Signature (if patient is a Minor)

Date

Signature of Witness

Date