Michele M Freeman, MS, NCC, LPC
354 NE Greenwood, Suite 212, Bend, OR 97701
Phone 541-408-4943 • Fax 541-330-1951
Email: mf@michele-freeman.com • Website: www.michele-freeman.com

HIPAA AUTHORIZATION FORM

I, _____, whose date of birth is _____,

authorize Michele M. Freeman to disclose to and/or obtain from

_____ the

following information:

Description of Information to be Disclosed:

____ Assessment

____ Testing Information

____ Diagnosis

____ Educational Information

____ Psychosocial Evaluation

____ Participation in Treatment

____ Psychological Evaluation

____ Continuing Care Plan

____ Treatment Plan or Summary

____ Progress in Treatment

____ Current Treatment Update

____ Other _____

____ for purposes of re-disclosure for treatment planning purposes.

Expiration:

Unless sooner revoked, this authorization expires on_____

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Therapist signature: Michele Freeman MS NCC LPC Date