BREENA FREID, LCSW
5225 OLD ORCHARD RD. SUITE 6, SKOKIE, IL. 60077
847-757-7711

CLIENT RECORD

Name ________________________________ Insurance ID number _________________________

Home address ____Zip___________________

Date of birth ____________________ Employer ____

Phone (Work) ________________ (Home) ________________ (Cell) ____________________

Name of policy holder, if different _______________________________Date of birth ___________

Address ____Zip___________________

CONSENT FOR RELEASE OF INFORMATION--INSURANCE

I authorize Breena Freid, LCSW to release to _____________________________________the following information (by phone or written report—faxed, emailed, or mailed) concerning my care, commencing __________________:

- ☐ Intake/assessment
- ☐ Dates of treatment
- ☐ Progress notes
- ☐ Discharge summary
- ☐ Client status and progress report
- ☒ All information necessary to meet benefit authorization and billing requirements

For the purpose of:

- ☐ Continuity of care
- ☐ Disability determination
- ☐ Evidence of care
- ☐ Aftercare services
- ☒ Reimbursement for treatment
- ☐ Other ________________________

I understand that I may revoke this consent at any time by giving written notice, except to the extent that Breena Freid has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. Because this consent is for third-party billing, it will not expire until all data is processed.

____ ______________________
Client's signature (age 12 and older) Date

____ ______________________
Parent/guardian of minor OR guardian of legally disabled recipient Date

____ ______________________
Witness signature Date