



WHITE OAK Counseling and Recovery

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Authorization for Scheduling, Billing and Payment Purposes

This form, when completed and signed by you, authorizes the person(s) whom you have indicated below to contact us on your behalf for scheduling, billing and payment purposes only.

I authorize _____

Please indicate your relationship with this person:

Spouse Significant other Parent/Guardian Other: _____

I authorize _____

Please indicate your relationship with this person:

Spouse Significant other Parent/Guardian Other: _____

I authorize _____

Please indicate your relationship with this person:

Spouse Significant other Parent/Guardian Other: _____

- This authorization will expire once the purpose of this disclosure ceases to exist, but no later than one year from the original date of signing.
- I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to White Oak Counseling and Recovery.

Client Name / Signature

Date Signed

Name / Signature of Person responsible for payment
(If other than client)

Phone number