

CROSSROADS

COUNSELING AND CONSULTATION

Consent for Release of Confidential Information

Email: info@crossroadsoftulsa.com Fax: 918-270-4101

I, _____, authorize Crossroads Counseling and Consultation

to disclose to:

to obtain from:

Person (s): _____

Organization: _____

Address: _____

City _____ State _____ Zip _____ Phone: () _____ - _____

Email: _____ Fax: _____

The following information is to be disclosed/obtained:

Name (s) of Client (s): _____

Date of Birth ____/____/____ Social Security _____

Medical History

Diagnosis Letter

Progress Notes

Psychiatric/Psychological Report

Treatment Plan

IEP/504 Letter

Termination/Discharge Summary

Other (Specify): _____

This disclosure is from the period beginning _____ and ending _____ for the purpose of _____.

This consent, unless expressly revoked earlier in writing, expires on _____

Signature of Client

Date

Parent of Guardian (if Client is a minor)

Relationship to Client

Witness

Date

This information is disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR, Part 2) prohibit any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

The information authorized for release may include information which may be considered a communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).