CROSSROADS

COUNSELING AND CONSULTATION

Consent for Release of Confidential Information

I, _____, authorize Crossroads Counseling and Consultation

☐ to disclose to: ☐ to obtain from:

Person (s): _____

Organization: _____

Address: _____

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

The following information is to be disclosed/obtained:

Name (s) of Client (s): _____

Date of Birth _____/_____/_____ Social Security _____

☐ Medical History ☐ Psychosocial History

☐ Progress Notes ☐ Psychiatric/Psychological Report

☐ Treatment Plan ☐ Psychological Testing

☐ 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 <u>not</u> 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).