Crossroads Counseling Services PLLC

Prompt, Professional, Courteous

- Individual & Family Therapy
- Substance Abuse Treatment
- Medication Management Treatment

Authorization to Release Information

____ I authorize Crossroads Counseling Services, PLLC to request records from the following office:
____ I authorize Crossroads Counseling Services, PLLC to release records to the following office:
____ I give Crossroads Counseling Services, PLLC permission to speak verbally with the following office:

____
(Specific Name of Facility or Clinician)

______________________ (Street Address) ______________________ (City, State, Zip)

______________________ (Phone Number) ______________________ (Fax Number)

( ) Private Clinician ( ) Hospital ( ) Family Member/Support Person
( ) Court System ( ) Self ( ) Other

The following information is regarding: ______________________ (Patient's Name) ____________ (Date of Birth)

Please release the following information:

____ Verbal Information	____ ALL INFORMATION
____ Medical Records	____ Lab Results
____ Medical History/Physical	____ Treatment Plan/Patient Progress
____ Psychological Evaluation (and/or Bariatric)	____ Discharge Summary
____ Social History	____ Results of Drug/Alcohol Treatment
____ Testing Results, including Tests	____ Other ______________

For the Purpose of:____

Appointment Date(s) of Service:____

Release Expiration Date:__________________ *Not to exceed one (1) year*

This authorization provides that:

- I may revoke this authorization at any time, provided that revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or it the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have a right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed authorization form showing when my records have been sent.

____ ______________________
Signature of Patient (12 years or older) OR responsible Party Date

____ ______________________
Signature of Witness Date

____ ______________________
Signature of Clinician Date