Crossroads
COUNSELING CENTER

Name: _____
DOB: _____
Chart #: _____
MID/Ins #: _____
MID/Ins #: _____

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

I hereby authorize Crossroads Counseling Center to exchange with and/or release information to the following:

Name: _____

Contact Person: _____

Address: _____

Telephone #: _____

Fax #: _____

This information shall include: **(check all that apply)**

- ☐ Any client information, including treatment compliance, treatment plan, progress notes, assessments, and results of psychological testing.
- ☐ Recommendations and treatment compliance
- ☐ Results of psychological testing
- ☐ Appointment verifications only
- ☐ Other _____

I understand this information shall be used for:

- ☐ Co-ordination of treatment and treatment planning
- ☐ Other: _____

Designated Care Giver and/or Foster Parent is permitted to sign treatment plan, participate in treatment plan decision making and on-going treatment.

(Initial Blank) _____

☐ This consent shall be valid for one (1) year from date signed.
☐ Other (specify date if consent is to expire in less than one year): _____

Redisclosure: Once information is disclosed pursuant to this signed authorization, I understand that federal health privacy law (45 CFR Part 14) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health information protected by state law (NCGS 122C) or substance abuse treatment information protected by state law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

Revocation and Expiration: I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in the Crossroads' Notice of Privacy Practices, a copy of which has been provided to me.

HIV/AIDS and Substance Abuse Release of Information: Check here if not applicable ☐
I understand there are special protections of HIV/AIDS information under GS 130A-143 and protections of Substance Abuse information per the confidentiality and disclosure requirements of 42 CFR Part 2.
By initialing beside the line, I do give consent to release information including: _____ HIV/AIDS _____ Substance Abuse

Notice of Voluntary Authorization: I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that Crossroads cannot deny or refuse to provide treatment, payment, or eligibility for services on my refusal to sign unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected information to such third party.

Signature: _____ **Date:** _____
Circle one: Client Parent Guardian