CROSSROADS COUNSELING CENTER
AUTHORIZATION FOR RELEASE AND/OR RECEIPT OF CONFIDENTIAL INFORMATION

Client: _____ DOB: _____

I/We hereby authorize _____ and Crossroads Counseling Center, located at 909 Main St., Suite 505, Dubuque, IA 52001, to release and/or obtain the information indicated below to:

Name of Person/Agency (list name of person and agency): _____
Complete Address: _____

The information being released /obtained will be used for the following purpose(s) by Crossroads Counseling Center:

___ Treatment planning/Implementation ___ Referral of new services ___ Coordination/monitoring of services ___ Other (specify): _____

Information to be released /obtained:

___ Social History ___ Progress Report ___ Treatment Plan ___ Medical History ___ Educational Records ___ Vocational Records

___Psychological Testing/Evaluation ___ Psychiatric Evaluation ___ Other: _____

This authorization is effective for 12 months (or ____) after the date it is signed. This release will automatically be revoked 30 days after discharge from Crossroads Counseling Center. I understand that I may review the disclosed information by contacting the directors of the Crossroads Counseling Center, 909 Main St., Suite 505, Dubuque, IA. 52001. Crossroads Counseling Center will not make the signing of the Release of Information a condition of your treatment, enrollment, or eligibility for services.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to:

___ Substance Abuse ___ Mental Health ___ HIV Related Information

Client Signature: _____ Date: _____

Parent/Guardian/Legal Representative: _____ Date: _____

In order for this information to be released, you must sign here and below.

Federal and/or state law specifically require that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDs-related information, must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORITY TO RE-DISCLOSE

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such person or entity, the information described above may be re-disclosed to other parties and will no longer be protected by the regulations.

Iowa and/or federal law provide that I have a right to prohibit re-disclosure of confidential information and further disclosure might not be had without my express written authorization, except as indicated below. I understand that the recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may re-disclose this information to:

A. _____ Administrative agencies (for example, the Department of Human Services), any judicial officers or court officials and their support staff, any parties (including opposing parties) and their legal counsel, social workers, service workers, school officials and employees, foster parents, other mental health or substance abuse counselors, and any other individuals involved in any pending court case with which I am associated.

B. _____ Other: _____

I understand that I may revoke this authorization by providing a written statement to the recipient named above and to the Crossroads Counseling Center. I also understand that any information released prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE.

_____ _____
Client Signature Date Parent/Guardian Signature Date

_____ _____
Witness Date