CROSSROADS COUNSELING CENTER

AUTHORIZATION FOR RELEASE AND/OR RECEIPT OF CONFIDENTIAL INFORMATION

Client: ____ DOB: ____________________________

I/We hereby authorize ________________________ and Crossroads Counseling Center, located at 300 Main St., Suite 230, 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 __

__ 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, 300 Main St., Suite 230, 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.

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