Crossroads Counseling Associates

11154 Huron St. Suite 209
Northglenn, CO 80234
303-920-8771
fax 303-920-8774

NAME:_____________________________________ DATE OF BIRTH:_____________

I hereby authorize _________________ (write therapist's name), to receive/furnish/exchange all confidential medical, psychiatric, educational, and/or other appropriate information acquired in the course of my evaluations and treatments (or those of my minor children).

Receive from/Furnish to/Exchange with:

____
(Name of Facility/Individual/Agency)

____
(Street address of Facility/Individual/Agency)

____
(City, State, Zip Code of Facility/Individual/Agency)

____
(Telephone #)

Purpose for which disclosure is being made:__________________________________

____

This consent is subject to revocation at any time, except to the extent that action has been taken in reliance upon this consent prior to notice of revocation.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

This consent expires: ____ 3 months ____1 year ____termination of current therapy.

Signature:____ Date:________________
(Client)

Witness:____ Date:________________

Special Signature Line:______________________________ Date:________________
(Parent/Guardian/Legal Representative)