

Crossroads Counseling Associates
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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL TREATMENT INFORMATION

Name: _____ **BD:** _____

DISCLOSURE REGARDING CONFIDENTIALITY OF TREATMENT INFORMATION
I understand that any treatment records concerning my medical treatment or mental health evaluations are confidential under Colorado law, and that a statutory privilege prohibits confidential treatment information from being disclosed without my consent. I understand that if I request records to be released to any person or health care provider, I am responsible for payment for expenses for the copying of the records, or that I will be responsible for payment for any summary of confidential health care information which is disclosed instead of specific records, at the discretion of my provider.

Name/address/phone of person(s)/agencies authorized to **(circle one)** release/receive/release and receive information:

Crossroads Counseling Associates, Ron Veatch, and Della Seaton are hereby released from all legal responsibility or liability for the release of the above-mentioned information. I understand that my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT FOR DISCLOSURE AT ANY TIME.

Date: _____ Signature: _____