Crossover Counseling

Authorization to Obtain or Release of Mental Health Information

I authorize the staff at Crossover Counseling obtain/release to/from: (circle one/both)

____

____
Counselor

____

______________________________	____________	__________________
Client Name	Date of birth	Date Effective Until/One Year

Information requested: ____

I authorize the disclosure of information (see above) and I understand that:

- *Federal law regulations of confidentiality and client privacy prohibits COC from releasing any information with specific exceptions without this express written authorization.*
- *The counselor may release a summary of treatment instead of the entire treatment record, to be decided upon by the counselor.*
- *I may revoke or cancel this authorization at any time, unless communication has already happened.*
- *This authorization will remain in effect for 1 year or the time specified above, to carry out the purpose for which permission is being given.*
- *As a legally authorized representative, the information disclosed may contain references about my family/myself.*
- *COC upholds Privacy Practices which I have received and signed. This more fully describes the procedures relating to my mental health care information.*
- *There exists a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected by these authorization requirements.*
- *I have the right to refuse to sign this and that Crossover Counseling will not withhold treatment.*
- *This includes the ability for verbal and written communication.*
- *I am releasing COC from all liability resulting from this release of information.*

I request the following limitations: (If any) ____

____________________________	__________________	____________
Client/Legal Representative Signature	Relationship	Date

A photocopy or facsimile transmission is as valid as the original.

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