



# *CrossRoads Counseling Centers*

1023 Executive Parkway Dr., Ste. 10, St. Louis, MO 63141

4228 S. Kingshighway Blvd., St. Louis, MO 63109

314.469.5522

www.stl-ccc.org

## AUTHORIZATION FOR THE RELEASE OF INFORMATION

RE: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

I hereby authorize the release of the following specific information:

- | <u>Yes</u> | <u>No</u> |   |
|------------|-----------|---|
| ___        | ___       | 1) Medical history, examination, laboratory tests, and treatment reports                      |
| ___        | ___       | 2) Psychological test reports   |
| ___        | ___       | 3) Psychiatric evaluation reports   |
| ___        | ___       | 4) Social history data, including family, education, employment, and other relevant materials |
| ___        | ___       | 5) Summary of current and/or previous mental health treatment                                 |
| ___        | ___       | 6) Periodic reports of current treatment progress, including attendance and participation     |
| ___        | ___       | 7) Notification of referral source of initiation and termination                              |
| ___        | ___       | 8) Specify: _____   |

From/To CrossRoads      From/To \_\_\_\_\_  
(name of agency or individual)

\_\_\_\_\_  
(address) (city) (state) (zip)

I understand this information will be used for the following specific purposes: (check all items)

- | <u>Yes</u> | <u>No</u> |  |
|------------|-----------|--|
| ___        | ___       | 1) To develop a diagnosis, treatment, and rehabilitation plan                |
| ___        | ___       | 2) To coordinate medical, psychological, and social rehabilitation processes |
| ___        | ___       | 3) Specify: _____  |

I understand no information may be released by either agency to any other agency or individual unless by my written consent. This authorization may be revoked at any time by my written statement, and it is **automatically revoked at the end of treatment unless otherwise specified.**

This consent for the release of information is given freely, voluntarily, and without coercion.

\_\_\_\_\_  
signature of client

\_\_\_\_\_  
signature of witness

\_\_\_\_\_  
signature of responsible adult for minor

\_\_\_\_\_  
relationship to minor

\_\_\_\_\_  
date