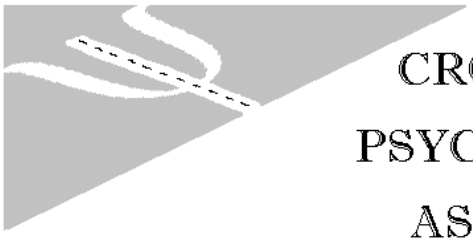

CROSSROADS PSYCHOLOGICAL ASSOCIATES

10784 HICKORY RIDGE ROAD • COLUMBIA, MD 20144-3646

PH. 410/964-0425 FAX 410/964-0515

CONSENT TO RELEASE OF INFORMATION

Communication between healthcare providers and/or among family members is important to help ensure that you receive comprehensive and quality care; however, your information will not be released without your consent. This information may include diagnosis, treatment plan, and progress and/or medication history.

PLEASE PRINT PATIENT INFORMATION

I, _____Date of Birth_____

_____
Address

_____
City State Zip Code

FOR THE PURPOSE OF COORDINATING CARE, AUTHORIZE

_____to
Provider Name

RELEASE TO AND/OR RECEIVE CLINICAL INFORMATION FROM:

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Telephone: _____ Fax: _____

Please indicate the information you authorize for release to the above-named party:
( ) Any applicable mental health/substance abuse information
( ) Only Medical Records during the period from _____ to_____
( ) Billing and Scheduling Information only
( ) Other: _____
( ) None

This information is sought for continued clinical care of the named patient. Unless permitted by State Statute, redisclosure of any information is prohibited without my specific written authorization. Consent will be valid without exception unless revoked in writing with revocation form obtained from therapist.

_____ _____

Patient Signature Provider Name

_____ _____

Patient Representative Relationship Date

HIPPA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment or to perform other specific health care operations.