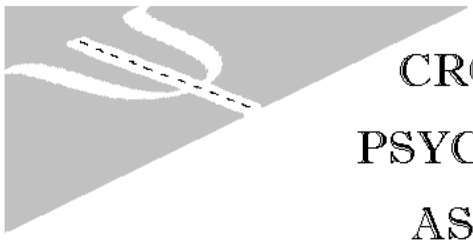

CROSSROADS
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AUTHORIZATION FOR RELEASE OF INFORMATION

Please Print Patient Information

Name_____ Date of Birth_____

Address

City State Zip Code

IN SIGNING THIS DOCUMENT I CONSENT AND AUTHORIZE THE INDIVIDUALS DESIGNATED BY MY INITIALS TO RELEASE TO AND/OR RECEIVE CLINICAL INFORMATION FROM THE FOLLOWING CLINICIANS:

Initials	Thomas W. Stacy, PhD	Initials	Laura C. Renbaum, MD
	David A. Gold, PhD		Matt Otto, M.S.
	Stephen J. Gaeng, PhD		Brenda L. May, LCSW-C
	Ana Garcia-Fernandez, PsyD		Bill Ray, LCSW-C
	David M. Band, M.D.		Elizabeth Ziskind, PhD
	Theresa Smith, LCPC		Libby Barritt, MS, LCPC, NCC
	All Mental Health Professionals at Crossroads may consult with each other		

THIS RELEASE IS IN REGARD TO TREATMENT FOR THE IDENTIFIED PATIENT DURING A PERIOD OF NO MORE THAN ONE YEAR:

FROM_____TO_____

Unless permitted by State Statute, redisclosure of any information is prohibited without my specific written authorization. Consent will be valid unless revoked in writing with revocation form obtained from the therapist.

_____ _____

Print Name of Patient DOB Therapist

_____

Authorized Signature for Patient

_____

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.