Teresa McCrossin, LCSW
Authorization to Release Records

I, _____ whose Date of Birth is _____, authorize Teresa McCrossin, LCSW to disclose and/obtain from:

_____the following information:

Description of Information to be disclosed

____Assessment
____Diagnosis
____Psychosocial Evaluation
____Psychological Evaluation
____Treatment Plan or Summary
____Current Treatment Update
____Medication Management Information
____Presence/Participation in Treatment
___Medical Information
___Drug screens/toxicological
___Education information
___Discharge/Transfer Summary
___Continuing Care Plan
___Progress in Treatment
___Demographic Information
___Other

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____

Conditions

I further understand that Teresa McCrossin LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization my have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information by this authorization in any manner that I deem to be appropriate with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further

disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:
_____

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc)

_____Check here if patient/client refuses to sign authorization.

Signature of Staff Witness Date