Crossroads' Turning Points, Inc.

AUTHORIZATION AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I,________________________________, hereby authorize and consent to the use or disclosure
(Client Name)
of my confidential information as described in this authorization.

(1) Crossroads' Turning Points, Inc. is authorized to provide this information.

(2) Crossroads' Turning Points, Inc. is authorized to provide this information to the following person/organization: (Psych-Who did the psych eval)-**Please list here**

(3) Crossroads' Turning Points, Inc. is authorized to provide the following specific information: Continuity of Care, Psychiatric Evaluation

(4) I understand that I have the right to revoke this authorization at any time by notifying Crossroads' Turning Points, Inc. in writing, at their address which is: 1711 East Evans Avenue, Pueblo, CO 81004

or such other address as is provided to me. I understand that the revocation is only effective after it is received and logged by Crossroads' Turning Points, Inc. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(5) I understand that my alcohol and/or drug treatment information is protected under federal regulations governing confidentiality of alcohol and drug abuse patient records or information 42 CFR Part 2 in the Health Insurance Portability and Accountability Act 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided in the regulations or as provided in the CTP Notice of Privacy Practices. Furthermore, I understand that after this information is disclosed, federal or state law might not protect it and the recipient might disclose it.

(6) I understand that as a client of Crossroads' Turning Points, Inc., release or disclosure of my information is subject to this authorization and any additional authorization that may be requested.

(7) I understand that I am entitled to receive a copy of this authorization.

(8) I understand that this authorization will expire on the __________day of ____________, 200__, or as follows: one year from date of signature

Signature of Client:______________________________ Date:____________________

Parent, Guardian, Personal Representative authorizations,

The undersigned is a parent guardian, personal representative or other authorized representative, as evidenced by documents provided to Crossroads' Turning Points, Inc. and has authority to sign this form.

____ ________________________

Signature of Parent, Guardian or Personal Representative Date

White Copy – Client Chart Yellow Copy – Client