Crossroads
Christian Marriage & Family Counseling

Consent and Authorization to Release Information of Records

Crossroads Counseling Center
P.O. Box 413 Brandon, MS 39042
601-939-6634
www.crossroadscounselingms.com

Pursuant to Federal Guidelines concerning my right to confidentiality, I, ________________________________,
(Patient Name)
authorize **Crossroads Counseling Center** and/or my **Therapist**, ______________________________, to release my records or information concerning my records to:

____
(Name of Specific Person or Organization)

I specifically consent only to the release of information of records pertaining to:

____

____

____
(Specific nature, reason for, and extent of information to be released)

I understand that I may revoke this consent at any time. However, any release which was made prior to my revocation will not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this consent to release information will expire when:

____
(State date, event or condition of expiration)

At that time no express revocation will be needed to terminate my consent.

____
Patient Signature **Date**

(If a patient is either underage or has a guardian appointed by the court, this release must be signed by the parent or guardian.)

____
Parent/Guardian Signature **Date**

Witness: ____

Updated: 04/14/2020