

**CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

Re: \_\_\_\_\_

By signing below, I hereby authorize:

Crossroads Institute for Psychotherapy and Assessment, at 3363 Linden Ave., Suite C.,  
Long Beach, CA. Ph# 424-201-1600, Fax # 424-201-1601,

AND

name of facility: \_\_\_\_\_

address, phone number: \_\_\_\_\_

to exchange clinical and assessment information related to my/my child's diagnosis and  
treatment for coordination of care. This consent will remain in effect for a year from the  
signature date, or until it is revoked in writing prior to that time.

\_\_\_\_\_  
Signature of adult client or parent/guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of signature