crossroads Institute for Psychotherapy and Assessment

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Re: _____

By signing below, I hereby authorize:

Crossroads Institute for Psychotherapy and Assessment, at 2601 Airport Drive, Suite 135, Torrance, CA, 90505. 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