CROSSWINDS
COUNSELING & WELLNESS

1000 Lincoln Emporia, KS 66801 Phone: 800 279-3645 Fax: 620 342-1021

Please select action needed:

☐	Send Records
☐	Request Info
☐	Service Letter
☐	File in Chart
☐	Send release only

Authorization for the Disclosure of Protected Health Information

Including Mental Health Information and/or Alcohol and Drug Records

Client First Name:		Client MI:		Client Last Name:	
Date of Birth:		Address:			
City/State/Zip:			SSN:	Telephone #:	

The information may be released to/obtained from:

Name/Agency:	
Specific Staff/Title:	Email:
Address:	Telephone #:
City/State/Zip:	Fax #:

I agree that the **PURPOSE OR NEED FOR DISCLOSURE** is indicated below: (Please review and select below)

☐ To Coordinate Treatment/Consultation ☐ To Advise the Court/Attorney/CRB ☐ To Transfer Treatment Providers
☐ To Involve Family in Treatment ☐ To testify or participate in court proceedings
☐ Other (specify): _____

I, the undersigned (client or Legal Representative) hereby authorize **CrossWinds Counseling & Wellness:**

(If not completed on computer, boxes will need to be initialed by client/legal representative)

Crosswinds to: **Release**	Crosswinds to: **Obtain**	
☐	☐	Any Mental Health Treatment Records, which are minimally necessary, including the diagnosis and records of any treatment or evaluations rendered to me.
☐	☐	Any Alcohol, Drug or Substance Abuse information.
	☐	Medical/Lab Reports.
	☐	School reports regarding grades and conduct.
☐	☐	Other (Specify):

VERBAL COMMUNICATION

☐ I authorize verbal communication with the entity listed above in order to coordinate treatment, allow discussion of treatment progress, and discuss relevant concerns or issues regarding the above named client's treatment.

DISCLOSURE LIMITATIONS: The information indicated will be disclosed unless there are specific restrictions noted below:

THIS DOCUMENT IS NOT VALID UNLESS ACCOMPANIED WITH A SIGNATURE PAGE