Anna Cross MEd, LPC
Individual and Family Therapy

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize Anna Cross, MEd, LPC and _____ to exchange verbal and/or written diagnostic, referral and treatment information about me.

Specific information to be released:

_____ Attendance information
_____ Chemical dependency treatment information
_____ Clinical progress information
_____ Diagnostic information
_____ Discharge information
_____ HIV status information
_____ Insurance information
_____ Medical history information
_____ Name and other identifying information
_____ Psychiatric information
_____ Referral information
_____ Other (specify):_____

The purpose of this exchange is to:

_____ Facilitate care _____ Insurance requirement _____ Probation / Parole requirement
_____ Other (specify): _____

I understand that my records and information are considered to be highly confidential and are protected under federal, state and local laws, rules and regulations as well as codes of ethics governing the practice of counseling and psychotherapy and cannot be disclosed without my written consent.

I hereby give my written consent to Anna Cross, MEd, LPC to disclose the information indicated above for the purposes noted above. I understand that this consent expires 6 months after my last date of service and that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.). I further understand that once I release information to the party listed above that Anna Cross, MEd, LPC can not ensure the confidentiality of that released material. A photographic copy of this authorization shall be considered as valid as the original.

_____ _____
Signature of client Date

_____ _____
Signature of parent, guardian or authorized representative Signature of therapist

I hereby revoke my consent as of this date. I understand that all records and information sent prior to this revoke were sent at my request. By signing this revoke, I request that Anna Cross, MEd, LPC send no further records, information or communicate with the party listed above regarding me and/or my case.

_____ _____
Signature of client Date

_____ _____
Signature of parent, guardian or authorized representative Signature of therapist

3400 Bissonnet
Ste. 270
Houston TX 77005

Phone 713.582.5981
Fax 855.570.2235
anna@acrosstherapy.com

18700 W. Lake Houston
Pkwy. Ste.102
Humble TX 77346