154 N Main St.
Cramerton, NC 28032
Phone: (980) 220-3516
Email: trish@crossbridgenc.com

Authorization for Release / Exchange of Information

Client Name: _____ _____Date of Birth: _____
(First Name) (Last Name) (mm/dd/yyyy)

I _____, do hereby authorize the ____release ____ exchange of:
(Client Name or Guardian)

___ Initial Assessment
___ Treatment Plan
___ Admission Summary
___ Attendance, Compliance and Progress in Treatment
___ Discharge Summary
___ Laboratory Reports
___ Psychological Testing
___ Medication
___ Billing Information

*****Information to be released to***** **or** *****Information received from*****

_____ _____
Name of Company/Facility/Person Name of Company/Facility/Person

_____ _____
_____ _____
_____ _____

(_____)_____-_____ Phone/Fax (_____)_____-_____Phone/Fax

Purpose of Disclosure:
___ Coordination of Care ___ Change of Doctor/Clinician ___Insurance/Medical Billing
___ Workers Comp ___ Referral ___ Personal
___ Other: _____

I understand that I may revoke my authorization at any time to the extent that the agency which is to release information has already acted in the reliance on it. If not revoked sooner, this authorization will expire upon _____ (date not to exceed one year) or when the following event or condition occurs: _____.

_____ _____
Signature of Client or Guardian Date