Authorization for Contact and Information Exchange

Can we contact you by:		Can we leave a message:		With whom:
Home Number	Y / N	Home Number	Y / N	
Work Number	Y / N	Work Number	Y / N	
Cell Number	Y / N	Cell Number	Y / N	

Can we **RELEASE** information to (If needed):		Can we **RECIEVE** information from (If needed):	
Physician	Y / N	Physician	Y / N
Psychiatrist	Y / N	Psychiatrist	Y / N
Hospital	Y / N	Hospital	Y / N
Family/Friend	Y / N	Family/Friend	Y / N
Other	Y / N	Other	Y / N

Information can be **RECEIVED** from or **RELEASED** to:			
	Name or Organization	Complete Address	Phone Number
Physician			( )
Psychiatrist			( )
Hospital			( )
Family/Friend			( )
Other			( )

If we need to contact you, we will do so based on your preferences and specifications indicated above. All information obtained and/or released, will remain confidential according to the conditions detailed previously regarding the Crossroads Counseling Center's privacy practices. Any information obtained or released, is for your counselor to further assist you in your therapeutic process. Client notification will occur before a medical professional or organization is contacted. Should you have any further questions, you may contact our office during business hours at (812) 518-1490 and we will do our best to assist you.

I have read the above and understand that the therapy relationship is a private and confidential one and authorize the recieving and releasing of information as I have noted above. I also autorize Crossroads Counseling Center to contact me by the aforementioned channels indicated above.

Client Signature: ______________________ Date: ______________

Witness Signature: ______________________ Date: ______________