



Crossroads Centre at Antigua

Willoughby Bay

P.O. Box 3592, St. John's, Antigua W.I.

Phone: 268-562-0035 Fax: 268-562-0036

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize

(PRINT CLIENT'S NAME)

CROSSROADS CENTRE at ANTIGUA

To disclose or receive from:

(Name of person(and relationship)/organization to which disclosure is to be made)

Address, city, state, zip, country and phone numbers

The purpose of the disclosure authorized herein is to:

<input checked="" type="checkbox"/>	AID IN TREATMENT STRUCTURE	<input checked="" type="checkbox"/>	CONTACT EMPLOYER
<input type="checkbox"/>	MEET PROBATION/PAROLE COND.	<input type="checkbox"/>	CONTACT LEGAL COUNSEL
<input type="checkbox"/>	COURT EVALUATION	<input type="checkbox"/>	CONTACT MEDICAL DOCTOR
<input type="checkbox"/>	MAINTAIN FAMILY CONTACT	<input type="checkbox"/>	CONTACT PROBATION/PAROLE
<input type="checkbox"/>	HAVE VISITATION	<input type="checkbox"/>	CONTACT INSURANCE CARRIER
<input type="checkbox"/>	CONTACT AA/NA SPONSOR	<input type="checkbox"/>	EMERGENCY CONTACT ONLY
<input type="checkbox"/>	CONTACT REFERRAL SOURCE	<input type="checkbox"/>	

To disclose/receive the following information:

<input type="checkbox"/>	PRESENCE IN TREATMENT	<input type="checkbox"/>	PSYCHOSOCIAL INFORMATION
<input type="checkbox"/>	EVALUATION INFORMATION	<input type="checkbox"/>	TREATMENT PLAN
<input type="checkbox"/>	INTAKE FORMS	<input type="checkbox"/>	DISCHARGE SUMMARY & RECOMM.
<input type="checkbox"/>	LEGAL HISTORY	<input type="checkbox"/>	FAMILY PROGRAM INFORMATION
<input type="checkbox"/>	MEDICAL HISTORY	<input type="checkbox"/>	FAMILY FEEDBACK FORM
<input type="checkbox"/>	AFTERCARE RECOMMENDATIONS	<input type="checkbox"/>	
<input type="checkbox"/>	PROGRESS IN TREATMENT	<input type="checkbox"/>	<u>OTHER</u>
<input type="checkbox"/>	PSYCHOLOGICAL/PSYCH. EVAL	<input type="checkbox"/>	

I understand that my records are protected under regulations governing Confidentiality of Alcohol/Drug Abuse Patient Records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also, understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year from which it is dated below and signed unless otherwise as designated as follows:

(Specification of the date, event, or condition upon which this consent expires)

Dated: _____

CLIENT'S SIGNATURE

WITNESS

"IMPORANT: This message is intended only for the use of the individual to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone."