



**CROSSROADS CENTRE, ANTIGUA
ALUMNI AUTHORIZATION AND CONSENT TO DISCLOSURE**

Crossroads Centre, Antigua offers Alumni services to support former clients of Crossroads and their family members (Alumni). Crossroads Centre employees and volunteers cannot disclose your personally identifiable health information- including that you or your family member(s) were patients at Crossroads Centre – to offer you alumni services without your written authorization.

I hereby authorize Crossroads Centre, Antigua to disclose my name, address, phone number and email address (“Contact information”) to Crossroads Centre alumni, alumni contacts and alumni volunteers for the purpose of providing and supporting alumni services and participating on the secure alumni website. By initiating the items below, I authorize Crossroads Centre to use or disclose my Contact Information as described above to provide the following alumni services.

- _____ Identify me as an Alumni Contact, willing to serve as a recovery resource to other alumni, by providing my name, phone number and address to newly discharged alumni.
- _____ Provide my name, phone number and address to an Alumni Contact who will act as a recovery resource for me.
- _____ Receive Communications from Crossroads Centre including, but not limited to e-mail, phone calls, regular mail and publications

This authorization shall become effective immediately and shall remain in effect until:

1. You inform Crossroad Centre that you no longer intend to participate in alumni services;
2. You inform Crossroads Centre that you no longer wish to receive communications from Crossroads Centre;
3. You revoke your authorization in writing

You may revoke your authorization at any time by contacting Crossroads Centre in writing at Alumni Services, P.O. Box 3592 St. John’s, Antigua, West Indies, or alumni@crossroadsantigua.org. Your authorization, however, may not be revoked to the extent that Crossroads Centre has acted in reliance on it.

I understand that I must maintain complete confidentiality for other alumni participating in these activities and further recognize that any breach of confidentiality could result in litigation from another client/alumni.

You have the right to inspect or copy your information that is used or disclosed in accordance with this authorization. You have a right to request restrictions on the use or disclosure of your personally identifiable health information.

While this authorization is required as a condition to Crossroads Centre offering you alumni support services, it is not required as a condition of providing you treatment, accepting payment or of your eligibility for benefits.

You may refuse to sign this authorization, but such refusal will prohibit your participation in the alumni website services and other alumni services outlined above.

You will be given a copy of this authorization for your records.

Alumni Name

Signature

Date

*Personal Representative

Authority to Act

*If you are signing as a personal representative of an Alumnus, please describe your authority to act for this individual (power of attorney, health care surrogate, etc.).