



# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Crossroads Wellness, LLC 7465 W. Lake Mead Blvd., Ste. 100 • Las Vegas, NV 89128  
702.480.4891 (Chad) • 702.480.4834 (Pam) • 702.562.1221 (Fax)

I, \_\_\_\_\_, authorize the following agencies or persons:

**Agency/Person(s) A**

**Agency/Person(s) B**

**Crossroads Wellness, LLC**

7465 W. Lake Mead Blvd.  
Suite 100  
Las Vegas, NV 89128

702.480.4834 (Pam)  
702.480.4891 (Chad)  
702.562.1221 (Fax)

Name: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_

To make the following transaction:

- Agency/Person(s) A** to disclose information specified below to **Agency/Person(s) B**
- Agency/Person(s) B** to disclose information specified below to **Agency/Person(s) A**
- Agency/Person(s) A and Agency/Person(s) B** to disclose information specified below to **each other**

Regarding: \_\_\_\_\_  
Client's Name

I authorize the release of the following information: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

This release is effective from: \_\_\_\_\_ to \_\_\_\_\_  
MM/DD/YY MM/DD/YY

***I understand that I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.***

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Witness/Counselor Signature

\_\_\_\_\_  
Date

***NOTICE:*** This information has been disclosed from records which are confidential. Any further disclosure without the written consent of the person to whom it pertains exceeds the limit of this release.