CROSSROADS Behavioral Health

10 North Main Street ● West Hartford CT 06107 ● Tel: 860-233-8111 ● Fax: 860-236-2016

RELEASE OF INFORMATION

TO: INSURANCE/MANAGED CARE COMPANY

I, _____ authorize
(Patient Name – please print)
CROSSROADS Behavioral Health to release an initial evaluation summary and progress reports/treatment plans and termination summaries as needed, to my insurance/managed care company for continuity of care purposes, or as may be necessary for the administration and provision of my health care coverage.

I understand that this consent shall remain in effect throughout the course of my treatment. I understand that I may revoke this authorization at any time by written notice to Susan E. Peterman, Ph.D.

_____ _____
Signature (if minor, parent/guardian signature needed) (Date)

_____
Witness