



# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

CROSSROADS WELLNESS, LLC

2660 Crimson Canyon Dr., Ste. 150 • Las Vegas, NV 89128  
702.480.4891 (Chad) • 702.480.4834 (Pam) • 702.254.9991 (Fax)

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

**Agency/Person(s) A**

**Agency/Person(s) B**

Chad L. Cross, PhD, MS  
NCC, MAC, SAP, LADC, MFT  
Crossroads Wellness, LLC  
2660 Crimson Canyon Dr., Ste. 150  
Las Vegas, NV 89128

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.