

Crossroads Adult Services

Consent to the Release of Information

Program Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BSU #: 071 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my permission to Crossroads Adult Services to release pertinent information to all providers who are affiliated with my care.

I hereby authorize all providers who are affiliated with my care to provide all available pertinent information to Crossroads Adult Services.

Program Participant Name Date

Program Participant Signature Date

Parent / Guardian / Caregiver Name Date

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Parent / Guardian / Caregiver Signature Date