# AUTHORIZATION TO RELEASE INFORMATION

I authorize: North Wind Behavioral Health
Clinician: ____________________________________________________________
1867 Airport Way, Suite 215, Fairbanks, AK 99701-4062
Phone Number: (907) 456-1434 Fax Number: (907) 456-1481

To (release to) / (receive from) / (both)**:** **PLEASE CIRCLE ONE**

Name: ____________________________________________________________

Address: ____________________________________________________________

City: ___________________________ State: ____________________ Zip: ____________________

Phone Number: ____________________________ Fax Number: ____________________________

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**Please place your initials** on the line(s) that describe the types of information you desire released.

_____ No Limitation
_____ Treatment Summary
_____ Assessment Report
____ Psychological Testing Information
____ Medical History, Physical Exam
____ Diagnosis, Services Provided, Dated

_____ Other specific limitations and/or dates: ____________________________________________

______________________________________________________________________________

This information will be used for my evaluation, treatment, follow-up care, and/or to determine benefits payable and claim insurance for treatment services.

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I hereby release both the above parties from any liability that may result from furnishing the information released. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that; in any event, this consent shall expire 90 days after completion of services provided by the North Wind Behavioral Health.

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations. It is understood that the policy of the North Wind Behavioral Health is to release only that information about a client or a former client which, in the judgment of the Clinician, is considered essential to the purposes for which authorization is requested.

Date: _______________ Client Name: ________________________________________DOB: __________________
(PRINTED)

Witness: __________________________________Client Signature: ________________________________________

Parent/Legal Guardian: ______________________________________