Second Wind Mental Health, LLC
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Authorization to Use and Disclose Health Information

Patient

Patient Name: _____
Birth Date: _____ Ph. #: _____ SSN: _____

From/To

I authorize the use and/or disclosure of the health information described below for the above-named patient by the following entities:

Information to be released FROM:	Information to be released TO:
_____	_____
_____	_____
_____	_____
□ Second Wind Mental Health □ Diane Rose	□ Second Wind Mental Health □ Diane Rose

Purpose

For the purpose(s) of:

☐ At the request of the patient or legal/personal representative

☐ Other purposes: _____

Info to be disclosed

Description of nature of information to be used and/or disclosed:

☐ Verbal Communication ☐ Medication records

☐ Laboratory reports ☐ Clinician/progress notes

☐ Other:_____

☐ All health records

☐ For the Following date range: _____to_____

(Excludes above Specially Protected information unless indicated by initials)

Specially Protected Information:
Please Initial:
_____ Mental Health/Psychiatric records
_____ Drug/Alcohol information
_____ HIV/AIDS/STD information
_____ Genetic Testing

Notices

1. I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, STD, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information, Federal law and regulation including 42 CFR Part 2 and 445 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.
2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.
3. I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of the above-named entity on its designated form. However, any such revocation will not apply to any activity undertaken based on this authorization. SWMH Joint Notice of Privacy Practices also describes how to revoke this authorization.
4. I received a copy of this authorization. I may inspect, or request copies of information disclosed by this authorization.

Dates

Unless revoked, this authorization will expire on the following expiration date: _____

Signature

SIGNATURE: I have read this authorization, and I understand it.

_____ _____ _____
Signature of Patient or personal representative | Date | Relationship to Patient

Staff Only

Date processed: _____/_____/_____

☐ Records sent by:_____ ☐ ADHI faxed for FYI _____ ☐ ADHI faxed for records _____