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: Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

I authorize: Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

To release to: North Wind Behavioral Health
Clinician: _____
1867 Airport Way, Suite 215, Fairbanks, AK 99701-4062
Phone Number: (907) 456-1434 Fax Number: (907) 456-1481

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

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

_____ 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 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.

Redisclosure is prohibited. Federal regulation 42 C.F.R., Part 2, prohibits any further disclosure of this information, except with the specific written consent of the person to whom it pertains. 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: _____