

WINGS
Authorization for Release of Protected Information

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulations.

Client Name _____ **Date of Birth** _____

Organization Exchanging Information:

Wings

1326 East Ripley St

Litchfield, MN 55355

320-593-0440

Organization Exchanging Information

Specific Description of Information to be released:

Discharge summary

Lab/UA Reports

Dimension Rating

Probation Information

Medical History

CD Evaluation and Recommendations

Progress Reports

Suspected Abuse/Neglect

Collateral Information

Other _____

This information is necessary for the following:

Diagnosis and treatment

Social Services Involvement

Other _____

Follow-up care

Update Records

This information may be exchanged in the following manners:

Verbal

Written

Electronic

WINGS

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Section B: Must be completed if provider has requested information.

1. The provider must complete the following:
 - a. What is the purpose of the disclosure?: _____

2. The client or the client’s representative must read and initial the following statement:
 - a. I understand that my treatment services or payment for these services will not be affected if I do not sign this form. Initials _____
 - b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials _____

Section C: Must be completed for all authorizations.

The client or client’s representative must read and initial the following statements:

1. I understand that this authorization will expire one year from date of signature on ____/____/____ (DD/MM/YY) Initials _____ Witness _____
2. I understand that I may revoke this authorization at any time by **notifying this treatment provider in writing**, but if I do, it will not have any effect on any actions taken before revocation was received. Initials _____ Witness _____
3. I understand that my records are protected by Federal Law (CFR 42 Part 2) and cannot be disclosed without this consent unless otherwise provided in the federal regulation. I also understand that I may revoke this consent at anytime except to the extent that action has been taken in reliance on it. (e.g. probation, parole, etc.) and that in any event, this authorization expires automatically as described above. My signature also means that I have read this form and/or have had it read to me and explained in a language that I understand.

Signature _____	Date _____
Parent/Guardian _____	Date _____
Wings Witness _____	Date _____

You may refuse to sign this authorization

You may use this form to release information for treatment or payment except when the information to be released is third party information.