

AUTHORIZATION FOR THE RELEASE AND RECIPEROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION

Client Name _____

Date of Birth _____

This form, when completed and signed by you, allows the exchange of protected health information between ClearWind Farm, LLC and the person or agency you designate below. This authorization is not a blanket wavier: it allows for specific information to be shared with specific people for a specific purpose, as indicated by you below.

The purpose of this disclosure is:

To assist with treatment To make a referral To allow for billing
 Other: _____

I am authorizing ClearWind Farm, LLC and Matt or Suzanne Case and the person or agency below to share protected health information about me or my child:

Person/Agency _____

Address _____

City/State/Zip _____

Phone: _____ Fax _____

I am authorizing only the following information to be released:

Client

<u>Initials</u>	<u>Information</u>
___	Psychological and/or psychiatric evaluation and diagnosis
___	Clinician or case manager treatment plan and/or service notes
___	Medication information
___	Verbal exchange regarding client evaluation and treatment
___	Intake and Discharge Summaries
___	School attendance record
___	School conduct information
___	Education achievement information
___	Verbal exchange with school personnel regarding client evaluation, treatment
___	Financial information required for reimbursement
___	Other: _____

This authorization will remain in effect until _____.

I may revoke this authorization at any time by giving written notice.

This authorization is fully understood and is voluntarily made on my part.

Patient's Signature

or

Parent or legally appointed representative's signature

Date of signature

Relationship

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.