WINGS
1326 East Riley St.
Litchfield, MN 55355
320-593-0440 320-593-0442

Authorization for Release of Protected Information
I hereby authorize the use of disclosure of my individually identifiable 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 ____________________________

Authorize WINGS to:
Yes No Give information Yes No Receive information

This information may be exchanged in the following manners:
____Verbal ____Written ____Electronic

Organization Exchanging Information:	
Address:	
Phone:	**FAX:**

Specific Description of Information to be released:
__Discharge summary __Lab/UA Reports __CD Evaluation and Recommendations
__Dimension Rating __Probation Information __Progress Reports
__Medical History __Collateral Information __Suspected Abuse/Neglect
Other_________________________

The purpose of the disclosure is:
__Diagnosis and treatment __Follow-up care Other ____________________________
__Social Services Involvement __Update Records

I understand that I may withdraw my consent by giving you a written notice of Revocation (not retroactive). This withdrawal will not apply to information that has been released in response to this authorization. I understand that a withdrawal will not apply to my insurance/billing company when the law provides my insurer/billing company with the right to consent a claim under my policy. Release of records may occur to a provider being consulted in connection with treatment or for claim payment one year from date I signed.

I understand that I have a legal right to refuse to sign this consent. If I refuse to sign this consent, treatment will not be withheld. I understand that I may revoke this consent (not retroactive) at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of cancelation. I understand that this consent expires one year after signature date. Other specifications of the date, event or condition upon which this consent expires: ______________________________________

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.

Client Signature____ Date ___________________

Parent/Guardian Signature _________________________________ Date ___________________

Wings Staff Signature ___________________________________ Date ___________________