WINDHORSE
INTEGRATIVE MENTAL HEALTH

Permission to Release Information Form

PERSONAL INFORMATION OF PROSPECTIVE CLIENT

ENTER FULL NAME

I _____, give permission to the following person(s) or organization for release of clinical and medical records to the staff of Windhorse named below. I understand that those persons authorized to receive my protected health information may not be subject to federal and state health information privacy laws.

*** This is to authorize the following person(s) or organization...**

NAME OR ORGANIZATION:

ADDRESS:

EMAIL ADDRESS:

PHONE NUMBER:

to disclose and release information as specified below to the following Windhorse staff:

LIST NAMES OF APPLICABLE WINDHORSE STAFF (separate by commas)

who is/are authorized to discuss all matters pertinent to the progress of the client. This information is instrumental to the ongoing evaluation and treatment of this client.

DATA REQUESTED:

- ☐ Psychiatric information
- ☐ Psychological testing
- ☐ Educational records
- ☐ Medical information
- ☐ Social welfare data
- ☐ Rehabilitation records
- ☐ Legal information

Other ☐

This authorization expires on ☐ *(or if not specified, 180 days from the date of the signature).*

DATE ☐

SIGNATURE _____

DATE OF BIRTH ☐

I understand that I may revoke this authorization in writing at any time.

Thank you. How to send us your signed release form? You have 3 options (email, fax or postal).

Please save, print, sign and email this completed PDF form to your selected location:
Northampton: AdmissionsEast@windhorseimh.org
Portland: AdmissionsWest@windhorseimh.org
San Luis Obispo: AdmissionsWest@windhorseimh.org

OR

Please save, print, sign and mail or fax to your selected location:
Northampton: (413) 585-1521 || 211 North St., Suite #1, Northampton, MA 01060
Portland: (800) 319-8261 || 2120 Southwest Jefferson Street, Suite #300 Portland, OR 97201
San Luis Obispo: (800) 319-8261 || 1411 Marsh Street, Suite #103, San Luis Obispo, CA 93401