Second Wind Fund
YOUTH SUICIDE PREVENTION

## AUTHORIZATION FOR RELEASE OF INFORMATION AND WAIVER OF LIABILITY FOR SECOND WIND FUND, INC.

I, _____, hearby authorize
**Name of Client** (Youth)

_____ _____
**Name of Referral Source** **Referral Source Contact Information** (email and or phone number)
(if applicable, i.e.: school counselor, mentor, doctor)

_____ _____
**Name of Therapist** **Therapist Contact Information** (email and or phone number)
(contracted Second Wind Fund therapist)

The purpose of this authorization is to disclose information that is relevant to my mental health treatment to Second Wind Fund, Inc., ("SWF"). I further understand that any treatment records concerning my mental health treatment are confidential under Colorado law, and that statutory privilege prohibits confidential treatment information from being disclosed without my written consent. This release of information expires in one year following completion or termination of treatment. This authorization may be revoked at any time in writing to SWF the referral source (*i.e.: school counselor, mentor, doctor*) and the therapist.

_____
**Client** (youth) **Signature / Date**

_____ _____
**Parent Signature / Date** **2nd Parent Signature, if required / Date**
(Or Legal Guardian with decision-making authority)

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### WAIVER OF LIABILITY

I, _____**,** waive and release any claim that I may have or that this client,

_____, may have against Second Wind Fund, Inc., ("SWF") its officers and directors, employees, agents, and members, the school that the client attends, the school district and all of their employees, for any negligence, claim, injury or damages whatsoever. This Waiver and Release is being made in exchange for the services which SWF will be paying for. **I understand that SWF is not providing services but funding them; and that no employee, Officer or Director of SWF will be providing services or treatment. I further understand that the treatment professionals to whom referrals may be made by SWF are independent professionals who are neither employees nor agents of SWF.**

*I am hereby informed that I should safeguard all obvious means for suicide, such as firearms, ammunition, and both prescription and over-the-counter medications.*
This Waiver is made freely and voluntarily, and I acknowledge that I have read this Waiver and understand it.

_____
**Client** (Youth) **Signature / Date**

_____ _____
**Parent Signature / Date** **2nd Parent Signature, if required / Date**

(Or Legal Guardian with decision-making authority)

***After this SWF Release/Waiver form is signed, please retain a copy for your files***