Second Wind Fund
YOUTH SUICIDE PREVENTION

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

I,_____ _____, hereby authorize
Name of Client (Youth) **Date of Birth of Client** (Youth)

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

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

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)

WAIVER OF LIABILITY

I,_____**,** waive and release any claim that I may have or that this client,
Name of Parent
(Or Legal Guardian or Client 12 years or older with decision-making authority)
_____, may have against Second Wind Fund, Inc., ("SWF") its officers and directors,
Name of Client (Youth)
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 return to SWF with your first claim and retain a copy for your files.
Updated 3/2024