

RELEASE/REQUEST FOR HEALTH INFORMATION

PATIENT NAME

DATE OF BIRTH

I hereby consent and authorize:

WYOMING BEHAVIORAL INSTITUTE

2521 East 15th Street

Casper, WY 82609

307-237-7444 fax: 307-472-2284

[ ] to release to

[ ] receive from

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

RELATIONSHIP TO PT \_\_\_\_\_

I understand that the information to be released includes information regarding Medical, Mental Health, Chemical Dependency and HIV/AIDS conditions.

Each item below to be released MUST be INITIALED to be valid.

I authorize the following information to be released/requested:

- DISCHARGE SUMMARY, PSYCHIATRIC EVALUATION, HISTORY/PHYSICAL EXAM, LABS/X-RAY/EKG/MRI/EEG, CONSULTATIONS, PHYSICIAN OUTPT NOTES, PSYCHOLOGICAL TESTING, MEDICATION INFORMATION, TREATMENT PLAN, EDUCATIONAL EVALUATIONS, VERBAL / E-MAIL COMMUNICATIONS, OTHER (SPECIFY)

(I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE, INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING: FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY AND TREATMENT HISTORY; AND HIV / AIDS)

PURPOSE:

I understand that the information will be used for:

- Further evaluation and treatment. Other

I understand that my behavioral health treatment records (including drug and alcohol) and information are protected under the federal regulations governing Confidentiality and Behavioral Health Patient Records, 42 CFR, Part 2, and the HIPAA Privacy Rule, 45CRF, Parts 160 and 164, and cannot be disclosed without my written authorization, unless otherwise provided for by the regulations I hereby release both the above parties from any liability which may result from furnishing the information released or requested. Without my expressed written revocation, this consent will expire in SIX (6) months from date signed.

If the patient is under the age of 18 and has had drug and/or alcohol diagnosis, treatment or education, Federal Regulations require us to obtain the signature of BOTH the minor and parent/guardian.

Patient Signature, Date, Signature of Legal Guardian (For Minor or Incompetent Patients), Date, Witness, Date