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: 307-472-2297

☐ 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 (including HIV/AIDS)
____ CONSULTATIONS
____ PHYSICIAN OUTPT NOTES
____ PSYCHOLOGICAL TESTING
____ MEDICATION INFORMATION
____ TREATMENT PLAN
____ EDUCATIONAL EVALUATIONS
____ VERBAL 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 form 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** **Date**
(For Minor or Incompetent Patients)

_____ _____
Witness **Date**