COMMUNITY HEALTH CENTER

COMMUNITY HEALTH CENTER
OF CENTRAL WYOMING
5000 Blackmore Road, Casper, Wyoming 82609
(307) 233-6000

Authorization for Disclosure of Protected Mental Health Information

_____ _____
Name of Patient Date of Birth

I hereby authorize the protected health information (PHI) of the above named individual to be:
☐ Obtained from and/or ☐ Released to

_____
Name of Organization Phone number

Address to include Street or PO Box, City, State and Zip Code

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) name above have taken action in reliance on this authorization.

This authorization expires on _____or twelve (12) months from the date of authorization.

Initials	ITEM	Initials	ITEM	Initials	ITEM
	Psychiatric Evaluation		Medical History		Substance Use History
	Clinical Assessment		Medications		Demographics
	Psychological Evaluations		Lab Findings/Special Studies		Other:
	Current Condition		Service Planning		Other:
	Symptom Assessment		Treatment Summary		Other:
	Diagnosis		Discharge Summary		Other:

For the purpose of _____

☐ *I understand that this authorization is voluntary and made to confirm my directions.*

☐ *I understand that my protected health information (PHI) may or may not be protected by Federal regulations under 42 CFR Part 2.*

☐ *As an alcohol and drug patient, I also understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations (42 CFR Part 2).*

☐ *In the event that any employee of Community Health Center of Central Wyoming is subpoenaed to testify in a civil or criminal proceeding, that employee is authorized to testify in any court.*

☐ *In criminal proceedings, I further understand that this consent is revocable after the final date cited above or upon the final disposition of the criminal proceeding against me.*

☐ *CHCCW fully complies with the HIPPA privacy rule under 45 CFR parts 160 and 164. The person receiving this information may re-disclose and use only to carry out that persons official duties with regard to the client's criminal proceeding with which this consent is given.*

In signing this authorization, the undersigned acknowledges that the records disclosed here might be subject to re-disclosure by/to persons not covered by HIPPA.

Patient Signature _____ Date _____

Witness Signature _____ Parent/Guardian Signature_____