T. 307.265.3791 **Wyoming Recovery** F. 307.265.4480
231 S. Wilson – Casper, WY 82601

Authorization to Obtain and/or Disclose Health Information

Patient Name: _____ Date of Birth:_____

Any other last name: _____ SS #_____

Name of the person(s)/organization(s) to whom the disclosure is to be made or from who the information is to be obtained

Name:	Phone #:	Fax:
Address:		
City:	State:	Zip:

Name:	Phone #	Fax:
Address:		
City:	State:	Zip:

By checking the spaces below, I authorize Wyoming Recovery to release/obtain the following specific medical records, if such records exist, from the past year or last encounter, unless otherwise specified. Note: Please do not fax/mail more than 20 pages.

Release	Obtain	Health Information:	Release	Obtain	Health Information:
☐	☐	Treatment Dates/Attendance	☐	☐	Discharge Summary/Continuing Care Plan
☐	☐	Medical History/Physical Exam	☐	☐	Verbal/Written Communication About Treatment
☐	☐	Psychiatric Assessment/Notes	☐	☐	Laboratory Reports
☐	☐	Medical Assessment/Notes	☐	☐	Other:
☐	☐	Assessment Instruments			
☐	☐	Clinical Notes			

PURPOSE: I understand that the information will be used for:

☐ Further evaluation and treatment ☐ Benefits/Insurance ☐ Legal (specify case type) _____

☐ Other (specify) _____

I understand that:

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Wyoming Recovery's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- I can revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. This authorization will expire in one year from the date I sign it unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42CFR §164.508(b)(4)(iii)].
- Communications resulting from this authorization will reveal that I received services at Wyoming Recovery.
- Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Wyoming Recovery to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by HIPAA rules.

_____ _____

Signature of Individual or Personal Representative Authorized by Law Date

To be completed by Wyoming Recovery Business Office:

Records requested by: _____ . *When records arrive, please forward to:* _____

Faxed: ☐ Mailed: ☐ Date: _____ Received Date: _____