COMMUNITY HEALTH CENTER OF CENTRAL WYOMING
We are your health

5000 Blackmore Road, Casper, Wyoming 82609
Phone: 307-233-6000
Medical Records Fax: 307-233-6013
Email: records@chccw.org

Authorization for Disclosure of Protected 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 acted in reliance on this authorization. ***Please allow 2 weeks for processing.***

This authorization expires on _____, or if no date is specified, one (1) year from the date of signature.

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

Records of care from _____ to _____ only.

For the purpose of: ☐ Continued Care ☐ Coordination of Care ☐ Other _____

Disclosure Requiring Special Consent: ____ HIV/AIDS

Please Note: By marking Complete Record does not mean that records containing information (if any) concerning HIV test results (AIDS) will be sent. If you would like these records sent, please mark the appropriate box. This PHI is being used or disclosed for the following purposes:

____ At the request of the individual (use only if request is by the patient or personal representative).

____ Other: _____

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

___ I understand that my PHI may or may not be protected by Federal regulations under 42 CFR Part 2, 45 CFR 164.524.

___ 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 the 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 HIPAA privacy rule under 45 CFR parts 160& 164. The person receiving this information may re-disclose and use only to carry out that person(s) 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 person(s) not covered by HIPAA.

Patient or Legal Representative Signature _____ **Date** _____

Parent/Guardian Signature _____ **Witness/Notary Signature** _____