CAMPBELL COUNTY MEMORIAL HOSPITAL P O BOX 3011 GILLETTE WY 82717 P (307) 688-1301 F (307) 688-1390 **MENTAL HEALTH & SUBSTANCE ABUSE** RELEASE OF MEDICAL INFORMATION	M# _____ V# _____ R# _____ A# _____

NAME OF PATIENT (PRINT PREVIOUS NAME, IF APPLICABLE) **DATE OF BIRTH** **TELEPHONE NUMBER**

PURPOSE OF DISCLOSURE: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified below, please specify:
Patient Care ____Self _____Other_____

SEND TO: Provider Name/Organization

_____

_____

PH: _____ FX: _____

RELEASED FROM: Provider Name/Organization

_____

_____

PH: _____FX: _____

If faxing records, they may be faxed to an unsecure fax line per patient request. Initials are required _____
INFORMATION TO BE DISCLOSED (Initial Each Item to Disclose): (Approximate Date of Treatment) _____

_____Assessment _____ Diagnosis _____ Psychosocial Evaluation _____ Psychological Evaluation _____ Psychiatric Evaluation
_____Treatment Plan or Summary _____Current Treatment Update ____ Medication Management Information _____Therapy Notes
_____ Presence/Participation in Treatment _____Nursing/Medical Information _____ Educational Information
_____ Discharge/Transfer Summary _____ Continuing Care Plan _____ Progress in Treatment _____ Demographic Information
_____Other_____

If Release of information includes Psychiatric, Alcohol, Drug Abuse or HIV results initials are required: _____

CCMH Hospital, Home Health, Pioneer Manor, HMR and CCMH owned clinics maintain their own individual medical records. Please contact them directly to obtain your records.

I understand that if this authorization includes disclosure of any PSYCHIATRIC, ALCOHOL and DRUG ABUSE records, the records are protected by virtue of the provisions of Federal Regulations 42 C.F.R. Part 2. I make this authorization upon the promise that the following notice shall accompany all disclosures of any ALCOHOL AND DRUG ABUSE records made pursuant to this authorization:

> This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal Regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I do hereby acknowledge that I have read, am familiar with, and fully understand the terms and conditions of this authorization. We will not condition treatment or payment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996.

_____ _____/_____/_____
PATIENT'S SIGNATURE / LEGAL REPRESENTATIVE'S SIGNATURE **DATE** **Time**

_____/_____
PRINT LEGAL REPRESENTATIVE'S NAME **RELATIONSHIP**

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient.

_____/_____/_____
WITNESS **DATE** **Time**

This authorization expires on _____. If no expiration date is indicated, this authorization will have expired 12 months from date of execution. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization.

COMPLETED BY CCMH STAFF ONLY: Release completed on:_____By: _____ # Pages released: _____