



# Campbell County Health

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Select group from which you are requesting records:

☐ CCH Mental Health & Substance Abuse

☐ Provider \_\_\_\_\_

Email: [ROI@cchwyo.org](mailto:ROI@cchwyo.org)

Fax: 307-688-1390

Mail: 501 S. Burma Ave  
Gillette, WY 82716

**Complete all sections entirely.** If this authorization is not complete, it may be returned and result in delay in processing.

Patient name \_\_\_\_\_ Formerly known as \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Purpose of Request: ☐ Continuation of Care ☐ Personal ☐ Legal ☐ Insurance ☐ Other \_\_\_\_\_

I authorize release to ☐ Self or (Name/Facility) \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ (if faxing records, they may be faxed to an unsecure fax line per patient request) **Initials Required** \_\_\_\_\_

Email \_\_\_\_\_

I acknowledge the risks associated with information sent via email that is not secured, and CCH is not liable for disclosure, misdirected or intercepted in transmission.

Date of service range (month/year) From: \_\_\_\_\_ to \_\_\_\_\_

If you released to self, select method of release: ☐ My Health Connections ☐ Email ☐ Mail

### Initial Each Item to Disclose:

\_\_\_\_ Assessment \_\_\_\_ Diagnosis \_\_\_\_ Psychological Evaluation \_\_\_\_ Psychiatric Evaluation \_\_\_\_ Treatment Plan/Summary  
\_\_\_\_ Current Treatment Update \_\_\_\_ Medication Management \_\_\_\_ Therapy Notes \_\_\_\_ Presence/Participation in Treatment \_\_\_\_ Education 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:** \_\_\_\_\_

### Patients' Rights:

- 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 protect by Federal law. Federal Regulation (42 C.F.R. Part 2) prohibits you from making any further disclosure of it with the specific written consent of the person to whom 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 that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/ AIDS related conditions, sexually transmitted diseases, and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy notes or Substance Abuse Disorder notes.*
- This authorization will expire one year from date signed.  
I understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail, email or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the insurers to contest a claim under policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. Research participation requires separate authorization by the patient. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are state in the United States Code of Federal Regulations at section 164.524.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Release of Information department where the request was submitted to.
- I understand if I am requesting my information while I am In House/Admitted or receiving on-going services, my record may not be complete, and I will need to request after services are completed and finalized. Records provided will be for treatment on the date of signature and/or Prior to signature date.
- There may be a charge for copies of records.
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Signature of Patient or Legal Representative \_\_\_\_\_

Date \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### Supporting documentation of authority must be provided. (Guardianship, Executor of Estate, Power of Attorney)

Release of Information; Medical Records: REV: 6/2015; 10/2016; 7/2017; 11/2023; 12/2025  
10/10/2016.

Committee Approval: Medical Records 11/15/2023

Date Initiated/Revised: 3/2013; 6/16/2015;

07/06/2017; 11/15/2023, 12/11/2025