CLOUD PEAK COUNSELING CENTER
401 South 23rd Street, Worland, WY 82401
Phone (307) 347-6165 Fax (307) 347-6166

Authorization for Release of Protected Health Information

Client Name:_____ D.O.B._____

I authorize Cloud Peak Counseling Center, to release/ received the following protected health information:

- ☐ Evaluation Report/ASI
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Treatment Progress
- ☐ Collateral Information
- ☐ Verification of attendance at treatment appointments
- ☐ Clinical Assessment
- ☐ Other (Specify) _____

For collateral information specify person's relationship to client:_____

to/ from the following person/ organization:

Name: _____

Address: _____

Phone: _____Fax: _____

This protected health information is being released/ received for the following reason:

☐ Compliance with court or probationary order ☐ Referral for additional services ☐ SA Evaluation
☐ Progress/compliance with treatment ☐ Other (Specify) _____

This authorization shall be in effect until:

Date: _____at which time this authorization to release my protected health information expires.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and 45 CFR Part 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Official at Cloud Peak Counseling Center at 401 South 23rd St., Worland, WY 82401. I understand that a revocation is only effective to the extent that the Center has not already relied on this authorization to release/ receive my protected health information.

Cloud Peak Counseling Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this authorization for the requested use or disclosure.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Client or Personal Representative Date

_____ _____
Witness Date