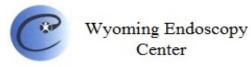


7212 Commons Circle Cheyenne, WY 82009



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## **Authorization for Release of Protected Health Information**

Phone: 307-635-4141

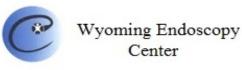
Fax: 307-638-2656

www.dhawy.com

Section 1	Patient Information	- PLEASE PRINT CLEARLY					
Patient Name:				Gender:	F /	М	
Date of Birth		Last 4 digits	Last 4 digits of Social Security Number:				
Phone Number:(		E-mail:					
Address:							
	Street	Cit	y Sta	te		Zip	_
Section 2	Information to be Re	eleased by: (Organization	providing the informa	ation)			
Organization's Name	2						
Address:							_
			Fax:				
Section 3	Information to be re	leased to: (Organization	receiving information)				
Organization's Name	2						
Address:							_
Phone:			Fax:				
Section 4	Information Request	ted (please be specific-typ	oe of information, date	e(s) of servi	ce, etc.)		
The following individ	dual identifiable health i	nformation should be disc	closed:				
Date(s) of Service:							
$\circ$	Lab (s) Offi	ce Notes	<ul><li>Medications</li></ul>	○ A	llergies		
This information wil	ll be disclosed for the pu	urpose of: Continuing	g Medical Care 🔘 A	ttorney/Cou	ırt Case		
Other (please sp	pecify):						



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## Section 5 Patient Authorization

This release will expire in one year following the issuance of this request. I understand that this authorization may be revoked by me at any time. I also understand that DHA will not withhold treatment if I do not sign this Authorization. I further understand that when my information is disclosed pursuant to this Authorization redisclosure by the recipient may no longer be protected by the Federal HIPAA Privacy Rule.

Signature:	Date:		
Relationship to Patient (if signing as legal guardian to patie	ent):	_	
This Authorization may be revoked by writing to:  I specifically authorize the release of information  Behavior Health			
<ul> <li>Substance abuse (including alcohomation (AIDS related information)</li> </ul>	• •		
Signature:	Date:		