ST. JOSEPH'S CHILDREN'S HOME
P.O. Box 1117 (307) 532-4197 (307)532-5921 Torrington, WY 82240
Fax: (307) 532-8405 or (307) 532-4024

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, agree to allow

Agency/Individual: St. Joseph's Children's Home
Address: P.O. Box 1117
Torrington, Wyoming 82240-1117
To the Attention of: Clinical Records

to release confidential information on _____ D.O.B. _____
This information is to be released to: _____
Agency/Individual: _____
Address: _____
To the Attention of: _____
Telephone No.:_____
Fax No.: _____

I authorize the following information to be released:

( ) Initial Evaluation/Social History and Preliminary Diagnosis
( ) Discharge Summary
( ) Education Assessment
( ) Psychological Screening and/or Evaluation
( ) Recent Treatment Reviews
( ) Aftercare Plan
( ) Other: _____

This information may be provided in the following format(s):
__Written __Verbal __Electronic

I understand the child's records are protected under Federal and State, confidentiality laws and regulations and will not be disclosed without my written consent unless otherwise provided for by laws or regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken on it. This consent expires automatically twelve (12) months from the date signed unless revoked in writing earlier.

If a drug or alcohol client: I make this consent upon the promise that all disclosures made pursuant to the authority granted by this consent shall be accompanied by a written notice which states as follows:

> "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, part 2) prohibit you from making any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose."

The information I authorize for release may include records which may indicate the presence of substance abuse or communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome.

I further acknowledge that I understand the effects of this authorization and consent it is given of my own free will.

_____ _____
Resident/Client Date

_____ _____
Legal Guardian Date

_____ _____
Witness (required) Date

An exact copy of this release is as valid as the original.