

**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:

- |  |   |
|--|---|
| <input type="checkbox"/> Initial Evaluation/Social History and Preliminary Diagnosis | <input type="checkbox"/> Recent Treatment Reviews |
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Aftercare Plan           |
| <input type="checkbox"/> Education Assessment  | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Psychological Screening and/or Evaluation                   |   |

This information will be sent in the following format:

Written     Verbal     Electronic     Other \_\_\_\_\_

I understand the child's records are protected under Federal and State Laws, confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the 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 the information to be released was fully explained and this consent 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.