FOUNDATIONS
Counseling & Consulting
Of Wyoming, LLC

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

NAME:	Date of Birth:	Social Security number

I request and authorize Foundations Counseling & Consulting of Wyoming to:

☐ Disclose and/or ☐ Receive to and/or from

Name of Person or organization			
Address:			
City	State	Zip	
Telephone Number	Fax Number		

The Date of records to be disclosed

From:	**To:**

I understand and approve that the information requested can contain: (Check all that apply)

☐ Attendance Records ☐ Medical Diagnosis ☐ Academic Records

☐ Clinical Assessments ☐ Progress in Treatment ☐ Consultation

☐ Police & Court Records ☐ Medical Records ☐ Explanation of Incident

☐ Payment Records ☐ Psychiatric Diagnosis ☐ Medical Injury/Illness

☐ Mental Health Records ☐ UA/BA results ☐ Inability to Drive

☐ Other Explain _____

For the purpose of the disclosure authorized in this consent is to:

☐ Coordination of Treatment ☐ Evaluation ☐ Illness/Injury/Emergency Transportation

☐ Other Explain _____

I understand that my treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
Specific Date:_____

Signature of Individual authorizing this Consent: _____
Date: _____
Signature of Witness: _____Date:_____