

Brighter Horizons Counseling, LLC
301 Richards Avenue
Gillette, Wyoming 82716

Telephone Number 307-685-6982

Fax Number 307-685-8054

Patient's Name: _____ Date of Birth: _____
Last names used in the past: _____ Social Security Number: ____ - ____ - ____

I authorize Brighter Horizons Counseling, LLC, to **Release** the following protected health information (check all that apply)

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Treatment Plan/Discharge Plan
<input type="checkbox"/> Assessment Instrument	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Laboratory Reports	about diagnosis, treatment,
<input type="checkbox"/> History & physical/Psych evaluations	progress, etc.
<input type="checkbox"/> Clinician and staffing notes	<input type="checkbox"/> Other _____

I authorize Brighter Horizons Counseling, LLC, to **Obtain** from you the following protected health information (check all that apply and initial): Please send material which may be relevant relating to approximately the past year or last encounter, unless otherwise specified.

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Treatment Plan/Discharge Plan
<input type="checkbox"/> Assessment Instrument	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Laboratory Reports	about diagnosis, treatment,
<input type="checkbox"/> History & physical/Psych evaluations	progress, etc.
<input type="checkbox"/> Clinician and staffing notes	<input type="checkbox"/> Other _____

Release to/Obtain from:

Name: _____ Organization: _____
Address: _____ Fax: _____

I understand that the information to be released or obtained may include information regarding drug/alcohol abuse/dependence and/or psychological/psychiatric conditions, as well as HIV/AIDS related information.

I certify this request has been made voluntarily and my contact information given above is accurate to the best of my knowledge. I understand I may revoke this authorization at any time, except to the extent this action has already been taken relying upon it. I hereby release all the above parties from any liability which may result from furnishing the information released or requested. Without my expressed written revocation, this consent will expire twelve (12) months from the date signed or on the following date or condition _____.

NOTICE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (42 CFR parts 2) (45 CFR parts 160 and 164) prohibit you from making any further disclosure of it without written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Signature of Individual or Personal Representative Authorized by law

Date:

Signature of Witness

Date:

To be completed by Brighter Horizons Counseling, LLC, Staff or Business office

Faxed

Mailed

Date: _____ Date Received _____