



Cheyenne Regional

Authorization for Release of Confidential Alcohol and Substance Use Disorder Information

Health Information Management
Cheyenne Regional Medical Center
214 E 23rd Street Cheyenne, WY 82001
Fax (307) 432-3108. Phone (307) 633-7925
Email: CheyenneRegionalHIM@crmcwy.org

By completing this form, I understand that my Substance Use Disorder (SUD) records are protected under federal law (42 CFR Part 2 and HIPAA, 45 CFR 160 & 164) and cannot be disclosed without my written consent and for purposes not identified in this form. This includes Alcohol, Cannabis, Hallucinogens (e.g., LSD, MDMA, PCP, psilocybin), Inhalants, Opioids (e.g., fentanyl, morphine, oxycodone), Sedatives, Hypnotics, Anxiolytics, Stimulants (e.g., amphetamines, cocaine), Tobacco, and Other or Unknown Psychoactive Substances. Any discloser made under this authorization will include the required federal confidentiality notice. I will not be denied services if I refuse authorization. If you would like other documentation other than SUD records, please fill out a general Release of Information.

(1) Participant Information	Legal Name:	Preferred/Previous Name(s):		
	Birth Date:	Phone Number:		
	Address:	City:	State:	Zip:

**(2)
Information
Released
FROM**

Cheyenne Regional Medical Center
 CRMG (Physician Clinics): _____

**(3)
Dates of
Service**

Dates of Service: FROM: _____ **TO:** _____
(required)

**(4)
Information
Disclosed
TO**

Individual/Facility/Organization OR SELF:

Attn/Dept:	Phone Number:	Fax:	
Address:	City:	State:	Zip Code:

**(5)
Information
to be
Released**

Specify the SUD records you would like to have released:

**(6) Purpose
of
Disclosure**

Personal Continuity of Care Workers' Comp Insurance Disability Legal Other _____
 There may be a charge/fee for copies of records.

**(7) Delivery
Method**

Information to be released on: MyChart Electronically CD Paper **Information needed by:** _____
 Send by: Email: preferred email address: _____ Encrypted Unencrypted
 MAIL PICK UP by Patient or Designee _____

**(8)
Authorization**

I hereby authorize Cheyenne Regional to release the health information indicated above to the Recipient named.
 1. I may revoke this authorization at any time in writing, but if I do, it will not have any impact on any actions taken prior to receiving the revocation.
 2. I understand fees for copy service may apply.
 3. I understand that my health care (or payment for care) will not be affected by whether or not you sign this authorization.
 4. 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

_____/_____
Patient's/Patient Representative's Signature **Print Name of Signee** **Date**
(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)
 Parent POA Guardian other ID verified by: _____
 Relationship to Patient (if not patient)
 This authorization will expire one year from signature date unless otherwise stated: _____

