Abintra Psychological Associates, LLC
175 Pine Street
Buffalo, WY 82834
307-684-5828 / Fax: 307-684-5803

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize Abintra to release / receive confidential information about:

Patient Name: _____ Date of Birth: _____

_____ to _____ from

_____
(Name/Organization/Address)

For the purpose(s) of: _____ Evaluation _____ Treatment _____ Other _____

Information to be released includes:

_____ Referral Information / Treatment Recommendations
_____ Alcohol / Drug Use History
_____ Psychological / Neuropsychological / Psychiatric Evaluation
_____ Medical Information
_____ Treatment Progress Notes
_____ Treatment Summary
_____ Other _____

Information may be released in the following form(s):

_____ Written _____ Verbal _____ Electronic / Fax
_____ Other _____

To the recipient of information: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

I (the undersigned) understand that my records are protected under Wyoming and Federal Regulations. I understand that if I have involvement in the criminal justice system I may not revoke a release to the criminal justice system until the involvement is completed (e.g., release from probation, return to prison, etc.). Without revocation, this consent will expire one year from date of signature. I waive and release Abintra from any liability resulting from the release of the above information.

_____ _____
Signature of Patient or Parent/Guardian (if patient is a minor) Date

Revocation of Release:

_____ _____
Signature of Patient or Parent/Guardian (if patient is a minor) Date

A PHOTOCOPY OF THIS AUTHORIZATION SHALL HAVE THE SAME VALIDITY AS THE ORIGINAL