RELEASE/REQUEST FOR HEALTH INFORMATION

PATIENT NAME: ______________________ DATE OF BIRTH: ______________________

I hereby consent and authorize: **DR. STEPHEN L BROWN & ASSOCIATES**
2417 E. 15TH ST
CASPER, WY 82609
□ to release to 307-234-3638
□ to receive from 307-472-2259 FAX

Name: ______________________
Address: ______________________
____
____
Relationship to Pt.: ______________________

I understand that the information to be released includes information regarding drug/alcohol abuse/dependence and/or psychological/psychiatric conditions. If you are court ordered to treatment, please be aware that by signing this release, you are authorizing us to appear in court and give testimony if so subpoenaed.

Each item to be released below **MUST** be **INITIALED** to be valid. No exceptions.

INFORMATION:

I authorize the following information to be released/requested:

________	HEALTH HISTORY INFORMATION	________	VERBAL COMMUNICATION
________	MEDICATIONS	________	EMAIL COMMUNICATION
________	PHYSICIAN OUTPATIENT NOTES	________	PROGRESS NOTES
________	SUBSTANCE ABUSE EVALUATIONS	________	TREATMENT PLANS
________	DIAGNOSIS INFORMATION	________	OTHER: ______________
________	PSYCHIATRIC EVALUATION		(PLEASE BE SPECIFIC)

(I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING: FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY; AND TREATMENT HISTORY)

PURPOSE:

I understand that the information will be used for: **(PLEASE INITIAL)**

________ Further evaluation and treatment
________ Other: ______________________

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except in the event that the action has already been take. Subsequent disclosure of my medical records by those receiving the authorized information is prohibited. I hereby release both the above parties from any liability which may result from furnishing the information released or requested. Without my express written revocation, this consent will expire in **ONE (1) YEAR** from the signed date.

If the patient is under the age of 18 and has had drug and/or alcohol diagnosis, treatment, or education, *Federal Regulations* require us to obtain the signature of BOTH the minor and parent/guardian.

______________________ ______________________
Patient Signature **Date** **Signature of Legal Guardian** **Date**
(For Minor or Incompetent Patients)

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Witness Signature **Date**

DS 101421