Wyoming Professional Assistance Program
Consent for the Release of Confidential Information
Non Treating Entity

Participant Name: _____
Other Names Used in Treatment: _____
Date of Birth: _____ Last 4 digits of Social Security Number: _____
Current Address: _____
Current Home Phone: _____ Cell Phone: _____

I, _____, hereby authorize ongoing direct communication and disclosure of my alcohol and drug treatment status and treatment records (including any medical, alcohol and drug history, including assessments or evaluations; information regarding my attendance, lack of attendance or participation in treatment sessions or continuing care program sessions; my cooperation with the treatment program or continuing care program; and my prognosis or progress in recovery) between staff of the Wyoming Professional Assistance Program and the following individuals:

Name of Organization: _____
Name of Contact at Organization (required): _____
Address: _____
Phone Number: _____
Fax Number: _____
Email: _____

- ☐ The purpose of and need for the disclosure is to (check one):
- ☐ facilitate coordination of my care between treatment providers
- ☐ to allow verification of participation and compliance in WPAP
- ☐ to allow verification of treatment program progress
- ☐ assessment of any concerns regarding my behavior in my work or home environment.
- ☐ uphold contractual agreement of my WPAP monitoring agreement
- ☐ Other: _____

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

_____.
[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, compliance with WPAP agreements or health care operations, if permitted by state law.

I have been provided a copy of this form.

Information disclosed may be protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other-wise permitted by 42 CFR Part 2. A general authorization for the release of medical or other 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 patient.

_____Date_____
(Client Signature)

- *Violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to the United States Attorney for the District of Wyoming, J.C. O'Mahoney Federal Courthouse, 2120 Capitol Avenue, Suite 4000, Cheyenne, Wyoming 82001, 307-772-2124;*
- *If you believe a violation of HIPAA has occurred, you may report that violation to the U.S. Department of Health and Human Services. For information on filing a complaint, go to https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html;*
- *Information related to a patient's commission of a crime on the premises of the part 2 program or against personnel of the part 2 program is not protected;*
- *Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected;*