



1656 East 12<sup>th</sup> Street, Casper, WY 82601

Phone: (307) 577-5718 Fax: (307) 577-5716

### AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I authorize Youth Crisis Center to **obtain** the following information:

diagnosis, treatment goals/planning, progress, attendance, discharge information,  
evaluations, assessments, behavior management plans/tools, crisis management plans/tools,  
safety plans, and related communication

I authorize Youth Crisis Center to **release** the following information:

relevant communication regarding case plans, goals, progress, discharge information,  
behaviors and behavior management needs/plans, crisis management needs/plans, safety  
plans/needs, and related communication

To/From:

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Fax: \_\_\_\_\_

For the **purpose** of:

case planning and service coordination; crisis planning and management; assisting with social,  
emotional, behavioral, and health needs; coordinating efforts

Without expressed revocation, this content expires on: \_\_\_\_\_

*I understand that I may revoke this authorization in writing at any time, unless action has already been taken based upon this authorization. Without expressed revocation, this consent expires one year from the date signed. I understand that this information is protected by HIPPA, DHHS, and Wyoming Statute 33-38-113 Privileged Communication and will not be released to anyone outside of this agency without written consent. **\*In case of emergency situations, the following information may be released without prior written consent: information requested by law enforcement such as current medications, medical history, court status, mental/emotional status.***

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Youth

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Parent or Legal Guardian