



Representative
Payee
Program

P.O. Box 2778
Cheyenne, WY 82003

Telephone: (307)635-8422
Fax: (307)635-0776

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize _____ to (circle one or both)
release to or receive from :

Wyoming Guardianship Corporation Representative Payee Program

Client initial for verbal and/or written information to be released and/or received:

- Representative Payee Records
- Billing Statements
- Housing Records
- Treatment Records
- Pharmacy information Records
- Legal Documents
- Financial or Accounting Records
- Other _____

Purpose or need for disclosure: To provide accurate and appropriate budgeting and financial services as Representative Payee.

I understand that my records are protected under the Federal Confidentiality regulations and cannot be disclosed without my written permission. I also understand that I may revoke my consent for disclosure in writing at any time, except to the extent that action has been taken. I acknowledge that the information released was fully explained to me and this consent is given of my own free will.

Executed this _____ day of _____, _____.
Day Month Year

Individual or Guardian Date

Federal Law (42 CFR, Part 2) prohibits making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose.