



Albany Community Health Clinic | (307) 766-3313  
 1174 N 22<sup>nd</sup> St. | Laramie, WY 82072

UW Family Practice | (307) 234-6161  
 1522 E. A St. | Casper, WY 82601

UW Family Medicine | (307) 632-2434  
 820 E. 17<sup>th</sup> St. | Cheyenne, WY 82001

**Educational Health Center of Wyoming (EHCW) HIPAA Form 3.2 A ROI  
 Patient Authorization Request to Send  
 Protected Health Information (PHI) to EHCW From Third Parties**

**Patient Legal Name:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

Requesting Records From:

<b>Name</b>		
<b>Address</b>		
<b>City</b>	<b>State</b>	<b>Zip</b>

**All records related to HIV/AIDS/STI, Drug or Alcohol Abuse, Behavioral/Mental Health must be specifically requested below.**

	Dates of Service (to/from) Be Specific
<input type="checkbox"/> All Records	
<input type="checkbox"/> Immunization Records Only	
<input type="checkbox"/> Lab Records Only	
<input type="checkbox"/> X Ray Records Only	
<input type="checkbox"/> Records from previous medical providers (please specify provider/organization names/locations below):	
Additional Information:	

**NOTE: If you are requesting release of any of the types of information below you must specify each one.**

	Dates of Service (to/from) Be Specific
<input type="checkbox"/> <b><u>All</u></b> Sexually Transmitted Infections Including HIV & AIDS	
<input type="checkbox"/> <b><u>All</u></b> Drug or Alcohol Abuse Records	
<input type="checkbox"/> <b><u>All</u></b> Behavioral/Mental Health Records	
<input type="checkbox"/> Limited Sexually Transmitted Infections Including HIV & AIDS, Drug or Alcohol Abuse Records, and/or Behavioral/Mental Health Records, specify dates of services and medical, behavioral/mental health issues to disclose (please specify below):	



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Please Send Requested Records to:

University of Wyoming Family Medicine Casper  
1522 East A Street, Casper, WY 82601  
Phone: (307) 234-6161/Fax: (307) 234-7032

I understand that my records and or those of any individuals listed above are protected under federal and state confidentiality regulations. I understand if I have authorized the release of drug abuse and or alcohol abuse information the confidentiality of this information is protected by federal law [42 CFR, part 2]. This information cannot be disclosed without my written consent unless otherwise specifically provided for in the regulations. Copies of this form may be used in lieu of the original. I understand and agree that this release may be sent to the agencies and persons identified above. EHCW must provide you a copy of the release. When my information is disclosed based on this authorization, EHCW no longer has control over how it's used or further disclosed by the receiving party. If the receiving party chooses to release information to other parties, it will no longer be protected by EHCW policies and federal privacy regulations. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining authorization.

*If no expiration date is provided, this authorization expires one year from date of signature; please specify your preferred date of expiration:*

- On the Following Date: \_\_\_\_\_
- Upon the Following Event: \_\_\_\_\_

**Printed Name:**  Patient  Parent  Authorized Representative

\_\_\_\_\_  
Printed Name of Patient, Parent or Authorized Representative

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_  
Representative's Authority to act for the Individual (ex. guardian, trustee, executor).

If signed by a Personal Representative of the individual, we must verify that you are this individual's representative under state law for purposes of filing this Authorization before we can act on it. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc.) As this person's representative, can you be contacted at the address above? If not, please provide your mailing address, email address and phone number here:  
  
\_\_\_\_\_