EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

Albany Community Health Clinic | (307) 766-3313
1174 N 22nd 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. 17th St. | Cheyenne, WY 82001

Educational Health Center of Wyoming (EHCW) - HIPAA Form 3.2 B2
Patient Authorization Request to Send Protected Health Information from EHCW to a Third Party

By signing this authorization, I _____ _____
Printed Name Date of Birth

Address:	Phone Number:
Other Patient Names Used if Applicable:	

authorize Educational Health Center of Wyoming (**"**EHCW") to disclose specific Protected Health Information (PHI) to the party(ies) listed below.

Send Records To:

Name:			
Address:			
City:	State:	Zip:	Phone:

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
□	All Records from EHCW	
□	Immunization Records Only	
□	Lab Records Only	
□	X Ray Records Only	
□	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
□	***All*** Sexually Transmitted Infections Including HIV & AIDS	
□	***All*** Drug or Alcohol Abuse Records	
□	***All*** Behavioral/Mental Health Records	
□	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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Reason for Records Transfer From EHCW:

When my information is disclosed based on this authorization, EHCW no longer has control over how it is used or further disclosed by the receiving party. Information released to EHCW will not be further transferred. If the receiving party chooses to release this information to other parties, it will no longer be protected by the EHCW policies and Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information and psychiatric/mental health information.

I have the right to revoke this authorization in writing by submitting the written revocation to Ms. Michelle Sanders, EHCW's /HIPAA Privacy/Security Officer at 1522 East A Street; Casper, Wyoming 82601. However, I understand that I may not retroactively revoke this authorization for information already released by EHCW in accordance with this Authorization.

All medical records will be copied for the patient free of charge the first time requested. Additional requests for copies may result in a fee to cover copying costs. Treatment, payment, enrollment, or eligibility for benefits may not be a condition of obtaining the requested 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:

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