EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

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

Wyoming Family Practice | (307) 234-6161 **UW Family Medicine** | (307) 632-2434

Educational Health Center of Wyoming
HIPAA Form 3.2 C
Patient Acknowledgement
Authorization for Use and Disclosure of Protected Health Information

I understand that:

1. I have been given the opportunity to review the Educational Health Center of Wyoming ("EHCW") Notice of Privacy Practices and have had an opportunity to ask any questions I may have.
2. Signing this authorization is strictly voluntary, I may refuse to sign this authorization.
3. My treatment, payment, enrollment, or eligibility for benefits ***may not*** be a condition of signing this authorization.
4. I may revoke this authorization at any time in writing; If I choose to do so, my revocation ***will not*** have any effect on actions taken prior to EHCW receiving my revocation.
5. If the requester or receiver of my Protected Health Information (PHI) is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that I will receive a copy of the form after I sign it; or if I choose not to sign it.

Patient Name:	
Date of Birth:	Phone #(s):

Please let us know if you have a preference in the way we contact you (specific phone number, ~~voicemail, mail correspondence~~).

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If you wish, please specify a particular family member(s) or friend(s) to whom you wish to share PHI with, please provide their contact information below. **[Yes] or [No]**

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Patient Authorization	
I authorize Educational Health Center of Wyoming to disclose my information to the following individuals (Please provide full names and addresses):	
Print Name of Family Member/Friend	Phone Number of Family Member/Friend
Address (Street Number, City, and Zip Code of Family Member/Friend)	

Relationship of Family Member/Friend		Date of Birth of Family Member/Friend

Purpose for Disclosure
This authorization will expire on the following date or event listed below. If I do not specify an expiration date, the form will expire one year from the date of signature.
Patient Acknowledgement
I have read the above; I authorize the disclosure of my protected health information as stated.

Signature:	Date:
Witness Printed Name:	Witness Signature: