UNIVERSITY OF WYOMING
Albany Community Health Clinic
920 E. Sheridan St., Suite A
Laramie, WY 82070
(307) 460-9040
Email: achc@uwyo.edu

Authorization to Release Healthcare Information

Patient's Name:____ Date of Birth:____________
Previous Name:____ SS#__________________

I request and authorize

Provider's Name: ____
Address: ____
City:_______________________________State:_______________________Zip Code: ________________
Phone: ____________________________ Fax:_______________________ to release healthcare information
of the above named patient to **Albany Community Health Clinic. This request and authorization applies to:**

- ☐ Healthcare information relating to the following condition, treatment, or dates: _____________________

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- ☐ All preventative medicine procedures and screenings such as mammogram, pap, colorectal cancer results.
- ☐ All healthcare information.
- ☐ Other:____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the *released* information may no longer be protected by federal privacy regulations. I understand that I may inspect or obtain a copy of my protected health information to be disclosed. I understand that the information in my health record may include information relating to alcohol, drug abuse, mental health records, and/or other highly confidential information obtained during the course of my diagnosis and treatment. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may no longer be protected by federal privacy laws or regulations. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability or disclosure of the above information to the extent indicated and authorized herein.

I authorize my health care provider and a public health agency to collect and enter my or my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (liS). The liS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Definition: Sexually Transmitted Disease (STD) as defined by law, RON 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VORL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. Yes ☐ No ☐

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. ☐ Yes ☐ No

Patient/Guardian
Signature: ____ Date: ______________________

Witness Signature: ____ Date: ______________________

This Authorization Expires One Year After It is Signed