UNIVERSITY OF WYOMING
Albany Community Health Clinic
920 E. Sheridan St., Suite A
Laramie, WY 82070
(307) 460 – 9039
Email: achc@uwyo.edu

**Albany Community Health Clinic**
**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 Albany Community Health Clinic (ACHC) 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 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 UW FM receiving my revocation.
5. If the requester or receiver of my PHII 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; of if I choose not to sign it.

| | |
|---|---|
| Patient Name: | |
| Address (Please include City and State, and Zip): | |
| Date of Birth: | Phone #(s): |

Please answer the following questions to help us understand your preference regarding how UW FM should communicate with you. **Please circle Yes** or **No** to each of the questions below.

1. ACHC may call me at the phone number(s) specified above for reasons such as appointment reminders, medical insurance discussions, and reasons pertaining my clinical care including laboratory test results among other items. **[Yes] or [No]**
2. ACHC may call my office or place of employment for reasons such as appointment reminders, medical insurance discussions, and reasons pertaining my clinical care including laboratory test results among other items. **[Yes] or [No]**
3. With my consent ACHC, may mail to my home any items that would assist ACHC in their treatment, payment, and operations for my medical care examples may include appointment reminder cards and billing statements **[Yes] or [No]**
4. If I'm not home when ACHC attempts to call me, ACHC may leave a message on my answering machine for reasons such as appointment reminders, medical insurance discussions, and reasons pertaining my clinical care including laboratory test results among other items. **[Yes] or [No]**
5. If I'm not at home when ACHC calls, or if I'm unable to tell them myself ACHC may contact one of my family member(s) and/or friend(s) to inform them. **[Yes] or [No]**
6. If you wish just specify a particular family member(s)s friends or to whom you wish to share PHI with, please provide their contact information below. **[Yes] or [No]**

| **Patient Authorization** | |
|---|---|
| I authorize Albany Community Health Clinic 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 |
| | |
| | |
| 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: |

**Form Approved By:** _____

**Signature**

**Printed Name:** Joseph F Steiner
UW HIPAA Privacy Officer/Dean College of Health Sciences **Date** _____

**Form Approved By:** Educational Health Center of Wyoming Board of Directors **Date** _____