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 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:

Name		
Address		
City	**State**	**Zip**

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	
□	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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Please Send Requested Records to:

Albany Community Health Clinic
1174 N 22nd St. Laramie, WY 82072
Phone: (307) 766-3313/Fax: (307) 766-3316

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:

_____