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
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).

Patient Authorization	
Please provide name, and contact information for the person(s) you are authorizing to view or share your PHI.	
I authorize Educational Health Center of Wyoming to disclose my information to the following individual(s). Please provide their full names & date of birth, so we can verify their identity.	
Primary Family Member/Friend	
Print Name of Family Member/Friend	Phone Number of Family Member/Friend
Relationship to Family Member/Friend	Date of Birth of Family Member/Friend
Alternate Family Member/Friend	
Print Name of Family Member/Friend	Phone Number of Family Member/Friend
Relationship to Family Member/Friend	Date of Birth of Family Member/Friend
Alternate Family Member/Friend	
Print Name of Family Member/Friend	Phone Number of Family Member/Friend
Relationship to Family Member/Friend	Date of Birth of Family Member/Friend
Purpose for Disclosure	
This authorization will expire one year from the date of signature below unless I specify a different date of expiration here:	
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:

December 2016