EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

Albany Community Health Clinic | (307) 766-8813
1174 N 22nd St. | Laramie, WY 82072

UW Family Practice
(307) 234-6161
1522 E. A St. | Casper, WY 82601

UW Family Medicine
(307) 632-2484
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).

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]

Patient Authorization

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.

Print Name of Family Member/Friend	Phone Number of Family Member/Friend

Address (Street Number, City, and Zip Code 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:

Form Revised : 12/27/2023