



Albany Community Health Clinic | (307) 766-3313  
 1174 N 22<sup>nd</sup> 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. 17<sup>th</sup> St. | Cheyenne, WY 82001

**Educational Health Center of Wyoming (EHCW) - HIPAA Form 3.2 B2  
 Patient Authorization Request to Send Protected Health Information  
 from EHCW to a Third Party**

By signing this authorization, I \_\_\_\_\_  
Printed Name Date of Birth

Address:	Phone Number:
Other Patient Names Used if Applicable:	

authorize Educational Health Center of Wyoming (“EHCW”) to disclose specific Protected Health Information (PHI) to the party(ies) listed below.

Send Records To:

Name:			
Address:			
City:	State:	Zip:	Phone:

**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
<input type="checkbox"/>	All Records from EHCW	
<input type="checkbox"/>	Immunization Records Only	
<input type="checkbox"/>	Lab Records Only	
<input type="checkbox"/>	X Ray Records Only	
<input type="checkbox"/>	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
<input type="checkbox"/>	<b><u>All</u></b> Sexually Transmitted Infections Including HIV & AIDS	
<input type="checkbox"/>	<b><u>All</u></b> Drug or Alcohol Abuse Records	
<input type="checkbox"/>	<b><u>All</u></b> Behavioral/Mental Health Records	
<input type="checkbox"/>	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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\_\_\_\_\_

**Reason for Records Transfer From EHCW:**

\_\_\_\_\_  
\_\_\_\_\_

When my information is disclosed based on this authorization, EHCW no longer has control over how it is used or further disclosed by the receiving party. Information released to EHCW will not be further transferred. If the receiving party chooses to release this information to other parties, it will no longer be protected by the EHCW policies and Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information and psychiatric/mental health information.

I have the right to revoke this authorization in writing by submitting the written revocation to Ms. Richelle Keinath, EHCW's /HIPAA Privacy/Security Officer at 1174 N 22nd St, Laramie, Wyoming 82072. However, I understand that I may not retroactively revoke this authorization for information already released by EHCW in accordance with this Authorization.

All medical records will be copied for the patient free of charge the first time requested. Additional requests for copies may result in a fee to cover copying costs. Treatment, payment, enrollment, or eligibility for benefits may not be a condition of obtaining the requested 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: