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

1. EHCW 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. EHCW 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 EHCW, may mail to my home any items that would assist EHCW in their treatment, payment, and operations for my medical care an example would be appointment reminder cards **[Yes] or [No]**
4. If I am not home when EHCW attempts to call me, EHCW 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 EHCW calls, or if I'm unable to tell them myself EHCW may contact one of my family member(s) and/or friend(s) to inform them. **[Yes] or [No]**
6. 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]**

EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

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Patient Authorization	
I authorize Educational Health Center of Wyoming 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

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: