Wyoming Medical Center
1233 E. Second St. Casper WY 82601
Phone: 307-577-2436 Fax: 307-233-8133
(Hours: Monday – Friday, from (9:00 am to 4:00 pm)

Authorization for Use and Disclosure of Protected Health Information

Patient Name_____
(please print) Last First Middle
Address_____
Street City State Zip
Phone_____Date of Birth_____SS#_____

I authorize Wyoming Medical Center to use or disclose protected health information to:

Name:_____Phone/fax number:_____

Address:_____

Purpose for use/disclosure:_____

Date(s) of service to be used/disclosed:_____ **Paper Copy**:_____ **Electronic Copy: _____**

Information to be used / disclosed:
___ Pertinent Record (Physician dictations and test results)
___ Entire Record
___ Other – Please Specify: _____

Fees: **Paper Records:** 1 thru 20 free, additional pages are $0.25 per page with a $5.00 processing fee.
Electronic Records: 1 thru 20 free, additional pages are $0.13 per page with a $5.00 processing fee.

Specific Authorization to Disclose Sensitive Records
I understand that this authorization is to include use / disclosure of (please initial):
____Alcohol and/or drug abuse records ____Psychiatric records
____Sexually transmitted disease information ____HIV/AIDS information
*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Wyoming Medical Center has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Chief Privacy Officer, 1233 E. Second St., Casper WY 82601 or fax (307) 233-8133, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which the authorization expires is: _____, or one year.
- I understand that Wyoming Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law, if the recipient is not a "covered entity".
- I understand that the information being disclosed may contain information from non-WMC providers and that information may not be complete.

SIGNATURE_____**DATE**_____
Patient or Patient's Legal Representative
Printed Name of Legal Representative:_____

Legal Representative's Authority to Act for Patient:_____

PLEASE NOTE: THIS FORM MUST BE COMPETED IN ITS ENTIRETY, THANK YOU FOR YOUR COMPLIANCE