# Wyoming Health Medical Group, LLC

An affiliate of Wyoming Medical Center


**Sage Primary Care**
1020 S. Conwell
Casper, WY 82601
Phone: (307) 265-8300
Fax: (307) 233-8230

**Wyoming Brain & Spine Associates**
1020 E. Second St, #200
Casper, WY 82601
Phone: (307) 266-2222
Fax: (307) 233-0266

**Wyoming Nephrology**
419 S. Washington, #102
Casper, WY 82601
Phone: (307) 237-5047
Fax: (307) 235-4017

**Casper Pulmonary**
419 S. Washington, #102
Casper, WY 82601
Phone: (307) 577-0477
Fax: (307) 577-0479

**Wyoming Endocrine & Diabetes Clinic**
419 S. Washington, #202
Casper, WY 82601
Phone: (307) 233-0259
Fax: (307) 233-0260


## 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 Health Medical Group 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: _____

Information to be used / disclosed:

___Entire Medical Record
___Emergency Room Record
___Discharge summary
___History and Physical
___Consultation report(s)
___Operative/procedure report
___Lab reports
___Pathology report
___ Radiology reports/films
Other _____

***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 Health Medical Group, LLC 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: _____.
- 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".

**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.**