WYOMING AUTHORIZATION TO RELEASE HEALTH RECORDS

Client

Name (First, Middle, Last) | Previous Name(s)

Current Address

Previous Address (if applicable) ☐ Update address and phone number

Date of Birth | Phone Number

Information Released FROM

☐ Aging Division
☐ Behavioral Health Division
☐ Healthcare Licensing & Surveys
☐ Immunization Unit
☐ Kid Care CHIP (Division of Healthcare Financing)
☐ Medicaid (Division of Healthcare Financing)
☐ Office of Emergency Medical Services (OEMS)
☐ Public Health Nursing (specify county): _____
☐ Public Health Division
☐ State Long-Term Care Ombudsman
☐ Veterans' Home of Wyoming
☐ Women, Infants, and Children (WIC)
☐ Wyoming Life Resource Center
☐ Wyoming Pioneer Home
☐ Wyoming Retirement Center
☐ Wyoming State Hospital
☐ Other (specify) _____

Information Disclosed TO

☐ **SELF OR** ☐ Individual/Facility/Organization (listed below)

Attn/Dept: | Phone Number | Fax Number

Address | City | State | Zip

Delivery Method

Records should be sent by:

☐ Fax ☐ Mail ☐ Email _____
(Email Address)

☐ Pick up by Client or ☐ *Designee* _____
(Designee's Name)

For Child Caring Facilities Only:

☐ Direct access to client(s) immunization record in the Wyoming Immunization Registry (WyIR)

Information to be Released

Release the following records:

_____

Purpose of Disclosure

☐ Personal ☐ Continuity of Care ☐ Child Caring Facilities ☐ Other _____

Expiration

I understand this authorization will expire one year from the date it is signed, unless otherwise specified.
(Alternative Expiration Date: _____)

Revocation	I understand I may revoke this authorization, in writing, at any time, except to the extent that the Wyoming Department of Health has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice stating my intent to revoke this authorization to the Wyoming Department of Health, Office of Privacy, Security & Contracts, 401 Hathaway Building, Cheyenne, WY 82002 or fax (307) 777-7439.
Charges	I understand I may be charged a reasonable fee to receive or direct to a third party a copy of the information identified above to be disclosed. The Wyoming Department of Health will notify me of any required fees so I may have an opportunity to agree, alter, or withdraw my request prior to processing.

I understand information disclosed may include information related to the treatment of behavioral, mental health, drug, alcohol, or sexually transmittable diseases. I understand information being disclosed may be subject to redisclosure by the recipient and may no longer be protected. I understand I am under no obligation to sign this authorization. I further understand the Wyoming Department of Health may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

All requests MUST be accompanied with proof of identity, such as a photocopy of the signatory's state-issued driver's license.

_____ _____ _____

Signature Print Name Date

Relationship to Client (if not client):

☐ Parent ☐ Legal Guardian ☐ Other (specify) _____

FOR OFFICE USE ONLY:

Reviewed By: _____ Date: _____

Proof of Identity Reviewed: ☐ Yes ☐ No

Notes: _____

☐ Approved ☐ Denied (correspondence reference number: _____)