

Request for Access to Records Wyoming Department of Health

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), clients have a right to request a copy of their health information. Wyoming Department of Health (WDH) requires all requests to be in writing.

I hereby request access to health information for: ID Number (if applicable): Name: Date of Birth: Address: Date of Request: City, State, Zip: I understand information may include information related to the treatment of behavioral, mental health, drug, alcohol or sexually transmittable diseases. Specify the type of disease, accident, dates of treatment or other portion of records you are requesting. **Type of Access Requested** Charges ☐ **Inspection**. Please let me know when and where I may I understand I may be charged a reasonable fee to inspect or obtain inspect my records and the fee, if any. I understand that an copies of the specified records. I also understand WDH will notify me of any required fees so that I may have an opportunity to agree, alter, or employee of Wyoming Department of Health may be present and I may not mark or alter the record in any way. withdraw my request prior to processing. ☐ **Copies**. I would like copies of the records requested. ☐ I would like the information in the following format: **Signature:** ______ Print Name: Phone Number: Date of Signature: **If not signed by the patient*, please indicate the relationship: For Office Use Only: Documentation of Relationship: Comments: ☐ Guardian or conservator of an incompetent client Reviewed Beneficiary or personal representative of deceased client Attached □ Parent or guardian of minor client Other (specify) Date Processed:

State of Wyoming – Department of Health F-005; Request for Access to Records

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