USE OR DISCLOSURE AUTHORIZATION

Wyoming Department of Health

(For Exceptions to Treatment, Payment and Operations)

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Wyoming Department of Health (WDH) may not use or disclose protected health information (PHI) without an authorization, except as provided in the WDH Notice of Privacy Practices. A signature on this authorization indicates the client is authorizing the specific use and disclosure of PHI described herein.

I hereby authorize use/disclosure/use and disclosure of the following individual's PHI:

Name:	ID Number (if applicable) :
Date of Birth:	Address:
Date of Request:	City, State, Zip:

Revocation Section

I hereby revoke this authorization.

_____ _____

(Sianature) ***(Date)***

I hereby authorize the following WDH Division/Facility/Program *to disclose* the specified PHI for the purpose indicated:

WDH Division/Facility/Program:
Information to be disclosed:
Purpose of the disclosure:

I hereby authorize the following person/entity *to receive* the PHI:

Name:	Title:
Address:	Telephone:
City, State, Zip:	Fax Number:

I understand information disclosed may include information related to the treatment of behavioral, mental health, drug, alcohol or sexually transmittable diseases.

I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the WDH Compliance Office at 401 Hathaway Building, Cheyenne, WY 82002. I further understand any such revocation does not apply to WDH's actions taken in reliance on this authorization prior to revocation.

I understand this authorization will automatically expire one year from the date it is signed, unless otherwise specified. _____

(Alternative Expiration Date)

I understand I am under no obligation to sign this authorization. I further understand WDH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand I have the right to inspect and obtain a copy of any information disclosed pursuant to this authorization.

_____ _____ _____

(Signature) ***(Print Name)*** ***(Date)***

****If not signed by the patient***, please indicate the relationship:

- ☐ Guardian or conservator of an incompetent client
- ☐ Beneficiary or personal representative of deceased client
- ☐ Parent or guardian of minor client
- ☐ Other (specify) _____

For Office Use Only:

Documentation of Relationship:

- o Reviewed
- o Attached

Comments: _____

_____

_____

Date Processed: _____