



## AUTHORIZATION TO RELEASE HEALTH RECORDS WYOMING DEPARTMENT OF HEALTH

<b>Client</b>	Name (First, Middle, Last)		Previous Name(s)		
	Current Address				
	Previous Address (if applicable)			<input type="checkbox"/> Update address and phone number	
	Date of Birth		Phone Number		
<b>Information Released FROM</b>	<input type="checkbox"/> Aging Division <input type="checkbox"/> Behavioral Health Division <input type="checkbox"/> Healthcare Licensing & Surveys <input type="checkbox"/> Immunization Unit <input type="checkbox"/> Kid Care CHIP (Division of Healthcare Financing) <input type="checkbox"/> Medicaid (Division of Healthcare Financing) <input type="checkbox"/> Office of Emergency Medical Services (OEMS) <input type="checkbox"/> Public Health Nursing (specify county): _____ <input type="checkbox"/> Public Health Division <input type="checkbox"/> Other (specify): _____ <span style="float: right; margin-left: 20px;"> <input type="checkbox"/> State Long-Term Care Ombudsman  <input type="checkbox"/> Veterans' Home of Wyoming  <input type="checkbox"/> Women, Infants, and Children (WIC)  <input type="checkbox"/> Wyoming Life Resource Center  <input type="checkbox"/> Wyoming Pioneer Home  <input type="checkbox"/> Wyoming Public Health Laboratory  <input type="checkbox"/> Wyoming Retirement Center  <input type="checkbox"/> Wyoming State Hospital         </span>				
<b>Information Disclosed TO</b>	<input type="checkbox"/> <b>SELF OR</b> <input type="checkbox"/> Individual/Facility/Organization (listed below)				
	Attn/Dept:	Phone Number		Fax Number	
	Address	City	State	Zip	
<b>Delivery Method</b>	Records should be sent by: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Email _____ <span style="display: block; text-align: right; font-size: small;">(Email Address)</span> <input type="checkbox"/> Pick up by Client or <input type="checkbox"/> <i>Designee</i> _____ <span style="display: block; text-align: right; font-size: small;">(Designee's Name)</span> For Child Caring Facilities Only: <input type="checkbox"/> Direct access to client(s) immunization record in the Wyoming Immunization Registry (WyIR)				
<b>Information to be Released</b>	Release the following records: _____				

<b>Purpose of Disclosure</b>	<input type="checkbox"/> Personal <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Child Caring Facilities <input type="checkbox"/> Other _____
<b>Expiration</b>	I understand this authorization will expire one year from the date it is signed, unless otherwise specified. (Alternative Expiration Date: _____)
<b>Revocation</b>	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.
<b>Charges</b>	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): <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (specify) _____	
<b>FOR OFFICE USE ONLY:</b>	
Reviewed By: _____	Date: _____
Proof of Identity Reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes: _____ _____	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied (correspondence reference number: _____)	

## Instructions for Completing the Wyoming Department of Health Authorization to Release Health Records

**Client:** Print the client's – full, legal name &/or any previous names  
 Address & previous address (if applicable)  
 If you would like a previous address changed to the current address, check the box.  
 Date of birth  
 Client's phone number (if we have questions)

**Information Released FROM:** Select the Wyoming Department of Health (WDH) divisions/programs/facilities you want to release your health information.

**Information Disclosed TO:** Print the name of the individual/facility/organization who is to receive the information along with their full/complete address, city, state, and contact number. If the information is being released directly to the client, select self.

**Delivery Method:** Select how we should send the information. Only the patient may pick up the information, unless the patient authorizes a designee. The WDH division/program/facility will call the client's phone number to provide notification that records are ready to be picked up and confirm pick up location.

**Information to be Released:** Specify the records to be released. Include dates if possible.

**Purpose of Disclosure:** Select the purpose of disclosure.

**Expiration:** The authorization will expire in one year unless specified otherwise.

**Mail, fax, or email the completed and signed authorization with proof of identity to:**

Aging Division 2300 Capitol Ave, 4 <sup>th</sup> Floor Cheyenne, WY 82002 Fax: (307) 777-5340	Behavioral Health Division 122 W. 25 <sup>th</sup> Street Herschler Bldg., 2 <sup>nd</sup> Floor West, Suite B Cheyenne, WY 82002 Fax: (307) 777-5849	Healthcare Licensing & Surveys 2300 Capitol Avenue, Suite 510 Cheyenne, WY 82002 Fax: (307) 777-7127
Immunization Unit 122 W. 25 <sup>th</sup> Street Herschler Bldg., 3 <sup>rd</sup> Floor West Cheyenne, WY 82002 Fax: (307) 777-7996 Email: <a href="mailto:wdh-immrecords@wyo.gov">wdh-immrecords@wyo.gov</a>	Medicaid / Kid Care CHIP 122 W. 25 <sup>th</sup> Street Herschler Bldg., 4 <sup>th</sup> Floor West Cheyenne, WY 82002 Fax: (307) 777-6964	Office of Emergency Medical Services 122 W. 25 <sup>th</sup> Street Herschler Bldg., Suite 102E Cheyenne, WY 82002 Fax: (307) 777-5639
Public Health Nursing 122 W. 25 <sup>th</sup> Street Herschler Bldg., 3 <sup>rd</sup> Floor West Cheyenne, WY 82002 Fax: (307) 777-7278	State Long-Term Care Ombudsman 2300 Capitol Avenue, 4 <sup>th</sup> Floor Cheyenne, WY 82002 Fax: (307) 777-7439	Veterans' Home of Wyoming 700 Veterans' Lane Buffalo, WY 82834 Fax: (307) 684-7636
Women, Infants & Children (WIC) 122 W. 25 <sup>th</sup> Street Herschler Bldg., 3 <sup>rd</sup> Floor West Cheyenne, WY 82002 Fax: (307) 777-5643	Wyoming Life Resource Center 8204 Wyoming Highway 789 Lander, WY 82520 Fax: (307) 335-6792	Wyoming Pioneer Home 141 Pioneer Home Drive Thermopolis, WY 82443 Fax: (307) 864-2934
Wyoming Public Health Laboratory 208 S. College Drive Cheyenne, WY 82002 Fax: (307) 777-6442 Email: <a href="mailto:WDH-LabResultRequest@wyo.gov">WDH-LabResultRequest@wyo.gov</a>	Wyoming Retirement Center 890 Highway 20 South Basin, WY 82410 Fax: (307) 568-3887	Wyoming State Hospital 831 Hwy 150 South Evanston, WY 82930 Fax: (307) 789-8181

**If you are requesting health records from more than one Wyoming Department of Health division/program/facility, mail or fax the completed and signed authorization with proof of identity to the WDH Office of Privacy, Security & Contracts (OPSC), 401 Hathaway Building, Cheyenne, WY 82002 or Fax: (307) 777-7439. If you have any questions, please call OPSC at (307) 777-2990 or 1 (866) 571-0944.**