Wyoming Department of Health

AUTHORIZATION TO RELEASE HEALTH RECORDS
WYOMING DEPARTMENT OF HEALTH

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: _____)

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 6101 Yellowstone Road, Suite 186A Cheyenne, WY 82002 Fax: (307) 777-5340	Behavioral Health Division 6101 Yellowstone Road, Suite 220 Cheyenne, WY 82002 Fax: (307) 777-5849	Healthcare Licensing & Surveys 6101 Yellowstone Road, Suite 186C Cheyenne, WY 82002 Fax: (307) 777-7127
Immunization Unit 6101 Yellowstone Road, Suite 420 Cheyenne, WY 82002 Fax: (307) 777-7996 Email: wdh-immrecords@wyo.gov	Kid Care CHIP 6101 Yellowstone Road, Suite 259B Cheyenne, WY 82002 Fax: (307) 777-6964	Medicaid 6101 Yellowstone Road, Suite 210 Cheyenne, WY 82002 Fax: (307) 777-6964
Office of Emergency Medical Services 6101 Yellowstone Road, Suite 400 Cheyenne, WY 82002 Fax: (307) 777-5639	Public Health Nursing 6101 Yellowstone Road, Suite 420 Cheyenne, WY 82002 Fax: (307) 777-7278	State Long-Term Care Ombudsman 6101 Yellowstone Road, Suite 186A Cheyenne, WY 82002 Fax: (307) 777-5340
Veterans' Home of Wyoming 700 Veterans' Lane Buffalo, WY 82834 Fax: (307) 684-7636	Women, Infants & Children 6101 Yellowstone Road, Suite 420 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 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.