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 providing permission for the specific use and disclosure of PHI described herein. This authorization may be revoked at any time by signing and dating the revocation section of this form and returning it to the WDH Compliance Office.

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.

_____ _____

(Signature) ***(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 that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Wyoming Department of Health program listed above. I further understand any such revocation does not apply to persons, which have already acted in reliance on this authorization.

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 treatment or eligibility is not dependent on my signature.

I understand I have the right to inspect and to 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:

- Reviewed
- Attached

Comments: _____

_____

_____

Date Processed: _____