COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

CHCCW.org

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of the named individual's health information as described below.

Patient Name: _____ Patient DOB_____

Patient Address: _____ City: _____ State: _____ Zip:_____

Patient Telephone Number: _____

I HEREBY AUTHORIZE: COMMUNITY HEALTH CENTER OF CENTRAL WYOMING to release my medical records to:

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____Fax_____

Please include the following:

_____ Complete record

_____ Records of care from _____ to _____ only.

_____ Records of care concerning the following condition(s): _____

__X____Other (Specify): **Sports Physical Form 2018**

_____ Confer with other person orally about information in my medical record.

Disclosure Requiring Special Consent □ HIV/AIDS

Please Note: By marking Complete Record does not mean that records containing information (if any) concerning HIV test results (AIDS) will be sent. If you would like these records sent, please mark the appropriate box. ***Please note:*** Psychotherapy notes require a separate authorization for release. This protected health information is being used or disclosed for the following purpose:

☐ At the request of the individual (use only if request is by the patient or personal representative)

☐ Other (Please list the specific purposes): _____

_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law revokes my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date, event or condition _____. If I fail to specify a date, this authorization will expire in twelve (12) months.

I understand that authorizing this disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of health information I can contact the HIPAA Compliance Office at CHCCW.

I understand there is a fee associated with the reproduction of my medical records. I understand by signing this authorization, I am required to pay for the reproduction of my medical records in advance, even in the event I decide to cancel my request. In accordance with HIPPA standards, CHCCW will not bill me for the retrieval of my medical records.

Signature of Patient or Legal Representative/Date_____

If signed by Legal Representative, Relationship to Patient_____

Witness: _____