

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: Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
To release my medical records to: *COMMUNITY HEALTH CENTER OF CENTRAL WYOMING*

OR

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): _____

_____ Other (Specify): _____

_____ 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 HIPAA standards, CHCCW will not bill me for the retrieval of my medical record

*****Please allow up to two (2) weeks for records to be copied and sent.*****

Signature of Patient or Legal Representative: _____ **Date:** _____

If signed by Legal Representative, Relationship to Patient _____

Witness/NOTARY: _____