COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

PROTECTED HEALTH INFORMATION DESIGNEE FORM
5000 Blackmore Road Casper, Wyoming 82609

We are your *health*

Patient Name	**Date of Birth**

I understand that the individuals identified below will be treated by Community Health Center of Central Wyoming (CHCCW) as individuals involved directly in my or the registered patient's care and as such CHCCW will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making and cancelling appointments, consenting to individual patient care appointments (including vaccinations) or to any medical or dental treatment requiring written or informed consent, payment, or health care operations.

1. **Name of Designee:** ________________________________ Date of Birth: ________________

   Relationship to Patient: ____________________________ Phone Number: __________________

2. **Name of Designee:** ________________________________ Date of Birth: ________________

   Relationship to Patient: ____________________________ Phone Number: __________________

3. **Name of Designee:** ________________________________ Date of Birth: ________________

   Relationship to Patient: ____________________________ Phone Number: __________________

I understand that the above-named designees have a right to request and receive a Notice of Privacy Practices from Community Health Center of Central Wyoming (CHCCW). This document is an acknowledgment that the above-named patient or the patient's legal guardian has supplied CHCCW with one or more contacts, with whom they may use or disclose the patient's personal health information. CHCCW has made the Protected Health Information Designee available to patients so that they may identify individuals that have permission to consent to treatment and receive protected health information for the patient in the absence of the patient or the patient's legal guardian or representative. By signing below, I acknowledge that I have read and understand the above statements and accept the terms. I voluntarily sign this authorization and understand that my ability to receive health care from CHCCW will not be affected if I refuse to sign this authorization.

☐ **I decline to provide a protected health information designee contact for myself or my child currently.**

Signed: **X**____ ___________________
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Signed: **X**____ ___________________
Witness Signature Date