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 _____ ☐ Pick up by Client or ☐ *Designee* _____ *(Designee's Name)* ☐ Direct access to client(s) immunization record in the Wyoming Immunization Registry (WyIR) [Child Caring Facilities Only]			
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: _____)