



115 S Elm St  
Casper, WY 82601  
Ph:800979-3711 In State  
Ph: 866-32-2510 Out of State  
**FAX to 307-268-8332**

## AUTHORIZATION TO USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: \_\_\_\_\_

Previous Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I request and authorize **Wyoming/Wellness Health Fairs** to release my blood screening results of the patient named above to:

Name of Entity Or Doctor \_\_\_\_\_

Attention To \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Request(s) \_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the address listed above. I understand that a revocation is not effective to the extent that Wyoming Health Fairs has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to Wyoming Health Fairs from a third party if applicable.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.