Authorization to Use and Disclose Health Images
Wyoming Department of Health

<table>
<tr><td rowspan="4">Client</td><td>Name (First, Middle, Last)</td><td>Previous Name(s)</td></tr>
<tr><td colspan="2">Current Address</td></tr>
<tr><td colspan="2">Previous Address (if applicable) ☐ Update address and phone number</td></tr>
<tr><td>Date of Birth</td><td>Phone Number</td></tr>
<tr><td>Information Released FROM</td><td colspan="2">☐ 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)
☐ State Long-Term Care Ombudsman
☐ Veterans' Home of Wyoming
☐ Women, Infants, and Children (WIC)
☐ Wyoming Life Resource Center
☐ Wyoming Pioneer Home
☐ Wyoming Public Health Laboratory
☐ Wyoming Retirement Center
☐ Public Health Nursing (specify county): ____________________
☐ Public Health Division
☐ Wyoming State Hospital
☐ Other (specify): ____________________</td></tr>
<tr><td rowspan="4">Images Disclosed TO:</td><td colspan="2">[Check all that apply.]
☐ ______________ Public-facing webpages, ☐ __________ Printed Material,
☐ News Outlet, Reporter, Facility/Organization (listed below) or ☐ other (listed below)</td></tr>
<tr><td colspan="2">Name</td></tr>
<tr><td>Address</td><td>City</td></tr>
<tr><td>State | Zip | Phone Number</td><td>Fax Number</td></tr>
<tr><td>Delivery Method</td><td colspan="2">Only applicable for a disclosure of a health image to a News Outlet, Reporter, Facility/Organization.
☐ News Outlet or Reporter will take health image for their own use.
☐ WDH shall transmit the health image to News Outlet, Reporter, Facility/Organization by:
______________________________</td></tr>
</table>

Information to be Released	Release the following image: **[Include a description of the image and date the image was taken.]** ______________________________
Purpose of Disclosure	☐ At the request of the ___________ ☐ At the individual's request ☐ 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: ______________________)

Instructions for Completing the Wyoming Department of Health Authorization to Use and Disclose Health Images

Client: Print the client's – full, legal name &/or any previous names
Address & previous address (if applicable)
If you would like a previous address changed to the current address, check the box.
Date of birth
Client's phone number (if we have questions)

Information Released FROM: Select the Wyoming Department of Health (WDH) divisions/programs/facilities you want to use and disclose your health image(s).

Information Disclosed TO: Select if the image(s) may be posted on public-facing webpages and specify which public-facing webpages you approve, such as social media or websites; published in printed material (list the document name if known); and/or disclosed to news outlets, reporter or other. If you authorize the WDH to disclose your image(s) to a news outlet, reporter, or other, please print the name of the news outlet, reporter, facility/organization, or other who is to receive the image(s) along with their full/complete address, city, state, and contact number.

Delivery Method: Identify how WDH should send the image(s).

Information to be Released: Describe the health image(s). Include dates if possible.

Purpose of Disclosure: Select the purpose of the use and disclosure.

Expiration: The authorization will expire in one year unless specified otherwise.

Mail, fax, or email the completed and signed authorization with proof of identity to:

Aging Division 2300 Capitol Ave, 4th Floor Cheyenne, WY 82002 Fax: (307) 777-5340	Behavioral Health Division 122 W. 25th Street Herschler Bldg., 2nd Floor West, Suite B Cheyenne, WY 82002 Fax: (307) 777-5849	Healthcare Licensing & Surveys 2300 Capitol Avenue, Suite 510 Cheyenne, WY 82002 Fax: (307) 777-7127
Immunization Unit 122 W. 25th Street Herschler Bldg., 3rd Floor West Cheyenne, WY 82002 Fax: (307) 777-7996 Email: wdh-immrecords@wyo.gov	Medicaid / Kid Care CHIP 122 W. 25th Street Herschler Bldg., 4th Floor West Cheyenne, WY 82002 Fax: (307) 777-6964	Office of Emergency Medical Services 122 W. 25th Street Herschler Bldg., Suite 102E Cheyenne, WY 82002 Fax: (307) 777-5639
Public Health Nursing 122 W. 25th Street Herschler Bldg., 3rd Floor West Cheyenne, WY 82002 Fax: (307) 777-7278	State Long-Term Care Ombudsman 2300 Capitol Avenue, 4th Floor Cheyenne, WY 82002 Fax: (307) 777-7439	Veterans' Home of Wyoming 700 Veterans' Lane Buffalo, WY 82834 Fax: (307) 684-7636
Women, Infants & Children (WIC) 122 W. 25th Street Herschler Bldg., 3rd Floor West Cheyenne, WY 82002 Fax: (307) 777-5643	Wyoming Life Resource Center 8204 Wyoming Highway 789 Lander, WY 82520 Fax: (307) 335-6792	Wyoming Pioneer Home 141 Pioneer Home Drive Thermopolis, WY 82443 Fax: (307) 864-2934
Wyoming Public Health Laboratory 208 S. College Drive Cheyenne, WY 82002 Fax: (307) 777-6442 Email: WDH-LabResultRequest@wyo.gov	Wyoming Retirement Center 890 Highway 20 South Basin, WY 82410 Fax: (307) 568-3887	Wyoming State Hospital 831 Hwy 150 South Evanston, WY 82930 Fax: (307) 789-8181

If you have any questions, please contact the WDH Office of Privacy, Security & Contracts (OPSC), by mail at 401 Hathaway Building, Cheyenne, WY 82002, by phone at (307) 777-2990 or 1 (866) 571-0944, by email at wdh-hipaa@wyo.gov, or by fax at (307) 777-7439.