Wyoming Health Fairs / Wellness Health Fairs™
A Path to a Healthier You. . .
800.979.3711/866.320.2510

Office Use Only
Customer #_____
_____
_____

AUTHORIZATION FOR FAX RELEASE

Release of Protected Health Information - 45 CFR 164.508 – Release of Records to a Third Party

Patient Name _____
(Please print clearly—include alias or maiden name if appropriate.)

Date of Birth _____ **Daytime phone** _____

I hereby authorize Wyoming Health Fairs/Wellness Health Fairs to use or disclose my protected health information to:

Provider _____
(Nurse, or medical contact to send results)

Facility _____

Fax number: _____ Clinic telephone: _____

Additional Physician

Provider _____
(Nurse, or medical contact to send results)

Facility _____

Fax Number: _____ Clinic telephone: _____

I understand this authorization is valid for a one time release.
I understand that I may revoke this authorization at any time by sending written notification to the address listed below.
I understand information disclosed under this authorization might be re-disclosed by the recipient, and may no longer be protected by federal or state law.
I understand that I may ask for a copy of this authorization.

Patient Signature _____ **Date** _____

_____ _____

Printed name if signed on behalf of patient *Relationship*