Wyoming Department of Health

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Thomas O. Forslund, Director

Governor Matthew H. Mead

Authorization to Release Medical Information
Wyoming Medicaid

I authorize the Wyoming Department of Health, Division of Healthcare Financing, (Medicaid) and its authorized agents to release all medical information that is maintained by Medicaid and its agents including, but not limited to, the History Profile, dates of service, names of providers, diagnostic and treatment codes, treatments provided, and amounts paid to providers, to the individual(s), attorney(s), and/or insurance company or companies listed below:

Individual whose medical records are to be released:

Individual's mailing address:

Parties to whom the information is authorized to be released, including addresses and telephone numbers:

Date of accident/incident:

This authorization shall remain in effect and shall not expire until Medicaid receives satisfactory reimbursement related to the incident referred to above and issues a Release of its reimbursement right.

The individual signing this authorization may revoke the authorization at any time, provided that the revocation is in writing, except to the extent that:

1. The covered entity to whom information is released has taken action in reliance thereon; or
2. The authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

The individual may:

1. Inspect or copy the protected health information to be used or disclosed.
2. Refuse to sign the authorization.

Revocation of this authorization may be performed by sending a written revocation signed by the individual or his authorized agent to the Wyoming Department of Health, Division of Healthcare Financing, 6101 Yellowstone Road, Suite 210, Cheyenne, WY 82002, by certified mail, return receipt requested.

The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and will no longer be protected by law.

The Wyoming Department of Health will not condition treatment, payment, enrollment, or eligibility for benefits on the individual's providing authorization for the requested use or disclosure.

The purpose of this disclosure is to facilitate reimbursement to Medicaid for benefits that were provided to the individual related to an injury/accident/incident that occurred on the date listed above. Medicaid is obligated to pursue reimbursement under federal law (See 42 U.S.C. § 1396a(a)(25) and related state and federal laws, including Wyo. Stat. Ann. §§ 42-4-201 through 42-4-208). Use or disclosure of the health information authorized to be released under this authorization may result in reimbursement to Medicaid from a liable third party.

A copy of the signed authorization will be provided to the individual signing this authorization.

Signed:_____ Relationship: _____
(Self, Parent, Guardian, Conservator, Personal Representative / Executor or Power of Attorney)

Date:_____

STATE OF WYOMING)
) **ss.**
COUNTY OF_____)

The foregoing Authorization to Release Medical Information was signed and sworn to (or affirmed) before me on this _____ day of _____, 20____, by _____ in his/her capacity as self/parent/guardian/conservator/ other:_____.

WITNESS my hand and official seal.

_____
Notary Public

My Commission expires: _____