Patient Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Last M.I.

Other Name Patient may have on Record: Phone #:

Social Security #: Date of Birth:

**Releasing Records From:**

Name:\_\_\_Casper Women’s Care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_940 E. 3rd Street, Suite 202\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_Casper, WY 82601\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (307)237-5510 Fax: ( 307 )237-0607

**Releasing Records To:**

Name:

Address:

City/State/ZIP:

Phone:

**Please Send Copies of the Following:**

 All Records Clinic Notes Last Pap Pre-Natal Labs

 Other:

Reason for Needing Records:

Date Needed by:

\*This release is valid for one year after the date it was signed unless stated otherwise\*

Signature: Witness:

Date: Date:

Additional notes by Casper Women’s Care PC staff member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_