Wyoming Retina
Associates, PC

Douglas L. Holmes, M.D.
307 S. Jackson St.
Casper, WY 82601
Phone: (307) 237-3937
Fax: (307) 237-0670

PERMISSION TO RELEASE PATIENT RECORDS

From: _____

_____

_____

_____

_____

To: Wyoming Retina Associates, PC
307 S. Jackson St.
Casper, WY 82601
P 307-237-3937
F 307-237-0670

I, _____, grant permission to _____ to release my personal medical records to Wyoming Retina Associates, PC. This includes, all x-rays, cat scans and any other information pertinent to my treatment while under care of Wyoming Retina Associates. The medical findings and treatment disclosed should cover the period from _____ to _____ (or all records). In signing this request, I hereby release my practitioner from any laws governing the disclosure of confidential or privileged information.

_____ _____

Signature of Patient or Legal Guardian Printed Name