Wyoming Retina
Associates, PC

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PERMISSION TO RELEASE PATIENT RECORDS

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

To: ____
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I, _____________________________________, grant permission to Wyoming Retina Associates, PC to release my personal medical records to ____. 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