PO Box 7434
Jackson, WY
(307) 733-3900 – phone
(307) 739-7683 – fax

Request for release of medical records:

I, ____

Request (patient name if not self) ____________________________

Patient birthdate, ____________________

☐ Medical Records

☐ X-rays

☐ MRI

☐ Other______________________________________

To be sent to: (include e-mail address if you are requesting records only)

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Signature ____

Date ___________________________