



Casper Women's Care, PC

770 East 2ND Street
Casper WY, 82601
Phone: 307-237-5510
Fax: 307-237-0607

Patient Name (print): _____

First

Last

M.I.

Other Name Patient may have on Record: _____ Phone # _____

Social Security #: _____ Date of Birth: _____

Releasing Records From:

Name: _____

Address: _____

City/State/ZIP: _____

Phone: (____) _____

Fax: (____) _____

Releasing Records To:

Name: Casper Women's Care _____

Address: 770 East 2nd Street _____

City/State/ZIP: Casper, WY 82601 _____

Phone: 307-237-5510 _____

Fax: 307-237-0607 _____

Please mail, or fax records to Casper Women's Care as soon as possible

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: _____



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