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)

_____
_____
_____
_____

Signature _____

Date _____