CEDARS HEALTH, LLC

REQUEST FOR RECORDS RELEASE

The following individual has requested that his or her medical records be released and forwarded to:

Physician's Name: ____________________________________ Fax#__________________________

Street Address: ____

City: ____ State: ______ ZIP Code: _______________

Patient Name: ____

Birthdate: ________________________ Social Security Number: ____________________________

I hereby authorize the release of all necessary medical records to ____from date____/_____/_____ to _____/_____/______. I wish for them to be forwarded as soon as possible.

Date: ____________

Patient's Signature: ____

(or parent if patient is a minor)

Patient's Address:

___________________________ City: ___________________ State: ____ ZIP Code: ____________

Signature of Witness:____

- 428 South Durbin, Casper, WY 82601, F: 307.462.0922
- 6015 Sycamore Rd Cheyenne, WY 82009, F: 307.333.0487
- 1906 E. Cedar Street, Rawlins, WY 82301, F: 307.333.0485
- 1453-A Dewar Drive, Rock Springs, WY, 82901, F: 307.333.0486
- 813 Highland Ave, Sheridan WY 82801 F: 307.333.0488
- 716 College View Dr., Riverton, WY 82501 F: 307.462.0922