Jordan Valley Dermatology

Health Optimization LLC

RECORDS RELEASE REQUEST

I, _____, authorize the release of my records from:

_____

_____

_____

_____

I authorize the release of:

- ☐ All medical records
- ☐ Pathology/Lab reports
- ☐ Records dated _____ to _____
- ☐ Other (please specify) _____

To be released to the following party:

Jordan Valley Dermatology
428 South Durbin Street, Suite 103
Casper, WY 82601
Phone: 307.265.2936
Fax: 307-265-6575

Patient Signature: _____ Date: _____

Relationship to patient: _____ Patient D.O.B.: _____

Office Use Only

Records Recieved: / / Staff Member: _____

Request Sent: / / Staff Member: _____