Richard D. Green MD, FAAP
940 E. Third St. #102
Casper, WY 82601
307-577-4280

Medical Release Authorization Form

Records Requested From:	**Records Requested To:**
M.D. Name: _____	Richard D. Green M.D., F.A.A.P.
Street / P.O. Box: _____	940 E. Third St. #102
City, State, Zip: _____	Casper, WY 82601
Fax: _____ (If available)	Phone: 307-577-4280 Fax: 307-577-4283 ***Please do **not** fax if record exceeds 10 pgs

Reason for Request: _____ Changing MD _____ Moved _____Insurance Purposes _____Personal Use

I hereby authorize and request you to release any and all medical records and other pertinent patient information which may include, but is not limited to complete history, physicals, lab and x-ray reports, immunizations, alcohol or drug abuse, HIV, mental health, or communicable disease information, or any treatment or examination rendered.

Patient Name (please print): _____ **Date of Birth**: _____ /_____ /_____

Guardian's Name (please print): _____ **Phone**: _____

Address: _____
(Street or P.O. Box) (City, State) (Zip Code)

Relationship to Patient: _____
(parent, foster, grandparent, etc)

You may refuse to sign this consent. This consent may be revoked at any time upon written notice, except to the extent that any person or organization has already taken action in release thereon. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. This form must be received within 90 days of signing and is valid for 90 days after receipt.

Guardian's Signature: _____ **Date**: _____ / _____ / _____

Witness: _____ **Date**: _____ / _____ / _____

**Please note that there will be a $1.00 per page charge on medical records released to parents that are picking them up for their own use. A fax machine may be used to transmit this information, and may increase the risk of accidental disclosure of this information to unauthorized parties.