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Send Records TO Big Horn Pediatrics & Family Medicine

This form will only be used to release records to the individual or for treatment, payment, or health care operations purposes, as permitted by the Privacy Rule.

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Records: _____All _____Immunization _____Other

Obtain Records From:_____

Address:_____

Phone Number:_____Fax Number:_____

Send Records To: Big Horn Pediatrics & Family Medicine
38 N. Desmet Ave, Suite 1
Buffalo, WY 82834
Fax: (307) 285-9029

I certify that I am the biological/adoptive parent or legal guardian of the patient(s) listed above and that I have the legal right and responsibility to access and transfer records.

Signature:_____

Printed Name:_____

Relationship to Patient:_____

Date:_____