David Fall, MD · Julie Fall, MD
Mindy Keil, PA-C · Rachel Helms, PNP
Stefanie Garcia, PA-C · A. Dozier Tabb, MD

www.bighornfamilymed.com

Request Records FROM 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.

Requesting Records for: _____ Personal _____ Transferring _____ Continuation of Care

Send Records To: _____

Address: _____

Phone Number: _____ Fax: _____

Obtain Records From: Big Horn Pediatrics & Family Medicine
1308 W. 4th Street
Gillette, WY 82716
Phone: 307-687-1300 Fax: 307-682-1309

Patient Name: _____ DOB: _____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Records: _____All _____Immunization _____Other _____

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

Signature:_____ Date: _____

Printed Name:_____

Relationship to Patient: _____