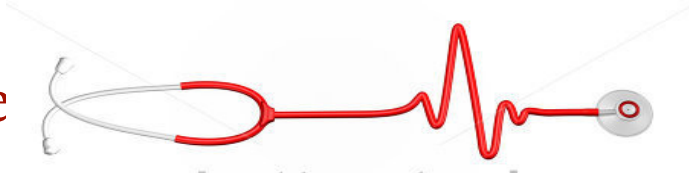
Wyoming Urgent Care



Because illnesses don't happen by appointment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient name: _____D.O.B._____

Address:_____

Telephone: _____

INFORMATION REQUESTED: (please be specific)

_____

_____

PURPOSE OF
RELEASE:_____

_____

_____

EXCLUSIONS IF
ANY_____

_____

I hereby authorize _____ to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work or other information unless otherwise excluded above. Information will not be released without a valid signature below. The authorization will expire 90 days from the signature date unless otherwise specified. I am aware that I may cancel this authorization in writing at any time.

Signature of patient (18 years of age or older)_____

Signature of the Guardian (if patient is minor) _____

Relationship to the patient _____

Expiration date of the authorization:_____