Jackson Hole Care For Women
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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____

This signed form authorizes medical information regarding the above-named person to be released

TO:_____ PHONE:_____

_____

_____ FAX:_____

I hereby consent to the release of my Medical Records including drug, alcohol, and mental health records obtained in the course of my diagnosis and treatment from Jackson Hole Care for Women. I understand that such information cannot be released without my specific consent except in a medical emergency.

A fee of $25 dollars for the first 25 pages, an additional $25 for the next 25 pages, and after $1 per page. There will be no charge for transfer of prenatal records for current prenatal patients.

Please email, fax, or bring the release form in person to Jackson Hole Care for Women.

Patient Signature:_____ DATE:_____