



1035 Rose Lane, Suite D • Riverton, Wyoming 82501 • Phone (307) 856-4688 • Fax (307) 856-1740

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

Patient Name _____ Date of Birth: _____

Address: _____

City/State: _____ Zip: _____ Phone #: _____

I authorize _____ to send a copy of my complete medical record, including all current transcription, to:

**Wind River Oncology
1035 Rose Lane, Suite D
Riverton, WY 82501
(307) 856-4688**

Signature of Patient or Legal Representative

Date

Print Name of Legal Representative and Relationship to Patient