Sheridan Orthopaedic Associates, P.C.
1050 Mydland Rd.
Sheridan WY 82801
Phone: 307-674-7469 Fax: 307-674-4619

Authorization for Release of Records

Patients Name: _____

Address: _____

City/State/Zip: _____

DOB: _____ Phone: _____

Please include the following records

_____ Progress Notes _____ Operative Reports _____ History & Physical

_____ Discharge Summary _____ Radiology Reports _____ Radiology Images

_____ Laboratory Results _____ Other (specify) _____

Please *send* my records to:

Facility/Doctor: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Please *get* my records from:

Facility/Doctor: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Authorized Signature: _____
(patient or legal representative)

Relationship if not the patient: _____

Release Effective Date: _____ Witness: _____

This authorization will expire in 6 months unless otherwise revoked.
Under penalty of perjury, I certify that all the information provided above is true and complete, and that Sheridan Orthopaedic Associates providers and staff have the right to rely on the information provided.