

# Wyoming Surgical Associates, P.C.

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## RELEASE OF INFORMATION

I AUTHORIZE:      Name: \_\_\_\_\_  
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TO RELEASE TO: Wyoming Surgical Associates, P.C.  
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& Robert C. Ratcliff, MD  
419 S. Washington, Suite 102  
Casper, WY 82601

All medical information contained in the medical records of :

Patient: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_  
Signature of Authorizing Party: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
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