



JENNIFER GRAHAM ALBANY COUNTY CORONER

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Request For Records: Agencies, Healthcare Facilities

Per WS §7-4-105 (d): I, the undersigned, request the Albany County Coroner's Office provide a copy of records regarding:

Full Name of the Deceased: _____

Date of Death: _____

Requesting Party Name: _____

Agency: _____

Address: _____

(Records will not be faxed or emailed)

Contact Number: _____

Court Docket or case number: _____

Agency Category:

- Law Enforcement entity of Wyoming or U.S. Government
- County, District, or U.S. Attorney
- County, State, or Federal Public Health Agency
- Board Licensing Healthcare Professionals under Wyoming Title 33
- Administrating division of WY Workers Compensation Act
- State Occupational Epidemiologist
- Administrating division of WY Occupational Health & Safety Act
- Office of the Inspector of Mines
- Insurance Company with legitimate interest in the death
- Party in a civil litigation with legitimate interest in the death
- Treating Physician
- State Health Officer per WS §35-4-115 (a) (i) & 35-4-107

Records Requested:

- Coroner Summary Report Autopsy Report Toxicology
- Photographs Video or Audio Recording

Albany County Coroner's Office is not Custodian to Medical Records

Secondary release of Medical Records is prohibited by Federal Law. Not all listed records are completed in every case. Per WS §7-4-105 (m), "A person who knowingly or purposely uses the information in a manner other than the specified purpose for which it was released or violates a court order issued under subsection (g) of this section is guilty of a misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than one thousand dollars (\$1,000.00), or both."

Requestor's signature: _____ Date: _____

Form of identification provided: _____

***After June 30th, 2015 there will be a charge of \$0.50 per page for copies, \$5.00 for CDs plus postage. ***

Coroner/Deputy witnessing requestor's identification: _____ Date: _____

FOR OFFICE USE ONLY

Date Records Sent: _____