AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:

DOB:

Phone Number:

I authorize Insight Primary Care, P.C. to release my medical records to:

Facility or Physician Name:

Phone:

Address:

City:

State:

Zip:

Records will be mailed directly to organization specified above. Please note: this process may take 14-21 days to complete. According to Colorado State Statutes, there may be a fee associated with your request which may be required in advance.

Signature: ________________________________ Date: _____________

Relationship to patient: