AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:

DOB:

Phone Number:

I authorize my records be released from:

Facility or Physician Name:

Phone:

Address:

City:

State:

Zip:

To be released to:

Insight Primary Care

2373 Central Park Blvd, Suite 205

Denver, CO 80238

P: 303.377.2494

F: 303.377.2548

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: