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 of patient or guardian Relationship Date