AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Phone Number: _____

I authorize release of my medical records from:

_____ _____
Facility or Physician Name Phone

_____
Address, City, State, Zip

To be released to:

Insight Primary Care, P.C.
2373 Central Park Blvd., #205
Denver, CO 80238
P: 303-377-2494
F: 303-377-2548

_____ _____ _____
Signature of patient or guardian Relationship Date