11960 Lioness Way Suite 190
Parker, CO 80134
Phone: 303-794-1111
Fax: 303-347-1341

INSIGHT VISION GROUP

Authorization for Release and Request for Medical Information

I hereby authorize and request the protected health information of:

Patient Name: _____ DOB: ____/____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Today's Date ___/___/_____

Reason for this authorization: _____

Check All Desired Items, Current To 7 Years, for the following date range: ___ /___ /_____ to ___ /___ /_____

- ☐ Eye Glass Prescription
- ☐ Contacts Prescription
- ☐ Exam Notes and Diagnosis
- ☐ Surgical (includes operative report)
- ☐ Diagnostic Test Results (retinal, corneal, visual fields, etc)

Requests take 30 days to process. If you will need your records before the 30-day limit, please inform us of the deadline here: ___/___/2021

Release FROM	**Release TO**
Name: _____	**Name:** _____
Address: _____	**Address:** _____
City: _____ **State:** _____ **Zip:** _____	**City:** _____ **State:** _____ **Zip:** _____
Phone: (_____) _____ - _____	**Phone: (_____) _____ - _____**
Fax: (_____) _____ - _____	**Fax: (_____) _____ - _____**

I may refuse to sign this authorization and my refusal will have no impact on receiving treatment. I can inspect or copy any information disclosed under this agreement. I have voluntarily signed this document. I can revoke this authorization at any time and the revocation must be in writing. I understand that the revocation will not apply to information that has already been released. I will receive a copy of this authorization if requested. The federal privacy laws will not cover the information released. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand this authorization will expire one year from date it was signed. I have carefully read and understand the above, have had any question explained to my satisfaction, and do herein expressly voluntarily authorize disclosure of the above information about or medical records of my condition to those persons or agencies listed above.

_____ _____

Patient or legally authorized individual signature Date

Please FAX this document to Medical Records 303.347.1341