INSIGHT VISION GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____Date of Birth: ___/____/_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____

RELEASE MY MEDICAL RECORDS FROM:

OPTOMETRIST INFORMATION (Please Print):

_____
_____
_____
_____

RELEASE MY MEDICAL RECORDS TO:

InSight LASIK South ____ 11961 Lioness Way Parker, CO 80134
Phone: 720-880-6455 Fax: 720-880-6460

InSight LASIK North ____ 4430 Arapahoe Avenue Suite 155 Boulder, CO 80303
Phone: 303-402-1000 Fax: 303-593-2199

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS – including, but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests.

Patient Signature: _____ Date: _____