MEDICAL RECORDS RELEASE

I am authorizing the following institution to release my complete chart records to Achieve Health:

Name of Institution:

_____

Name of patient _____

Date of birth: _____

Phone: _____

FAX the patients complete medical record to:

Achieve Health
F720-310-7216

P720-241-3765 for questions relating to this request

I request and authorize the release of my complete medical record to Achieve Health.
This authorization will expire in one year from the date of signature. I understand if records are to be printed that I am liable for any expense of printing and mailing my medical records and that such a fee will be made known to me before records have been sent.

_____ _____

Patient Signature Date