	FIT Wellness Center **1140 US Hwy 287, Ste 100** **Broomfield, CO 80020** **(303) 469-0353 Office** **(303) 469-1066 Fax** **info@BroomfieldWellness.com**

PATIENT REQUEST FOR RECORDS

Patient Name: ___________________________Date of Birth: ______________ Date: __________

I hereby authorize ____to release my X-rays/records
(Name of facility requesting from)
from dates: ______________ to __________________.

Please have them transferred to: *(Check name request is to be sent to.)*

Brian A Kenyon, DC-FIT Wellness Center
Scot Somes, LAc-FIT Wellness Center
Tara Quinan, CMT-FIT Wellness Center
Other:
Name ____
Address ____
City_____________________ State_______ Zip__________
Phone: ____
Fax: ____
E-mail: ____

Please submit x-rays/records in one of the following ways:

Mail address:
1140 US Hwy 287
Suite 100
Broomfield, CO 80020

Email digital:
info@BroomfieldWellness.com

Pick up by: _____________
____
____

Fax (303) 469-1066

I authorize the release of my x-rays/records. I understand they must live where they were taken and must be returned in 30 days according to state regulation.
Signature of Patient: ____ Date: _____________