FIT Wellness Center
1140 US Hwy 287 #100
Broomfield, CO 80020
303-469-0353
info@BroomfieldWellness.com

RECORDS REQUEST

Patient Name: ___________________________**Date of Birth:** ______________ **Date:** _____________

I hereby authorize (facility requesting from)____

to release my X-rays/records from (date) ________________ **to** (date) ____________________.

Please have them transferred to:

FIT Wellness Center

Other: Name ____
Address ____
City______________________ State_______ Zip__________
Phone: ____
Fax: ____
Email: ____

Please submit X-rays/records using one of the following methods:

Email *(preferred method)*:
info@BroomfieldWellness.com

Mail:
FIT Wellness Center
1140 US Hwy 287 #100
Broomfield, CO 80020

Pick up by:
____

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 if they are original, according to state regulation.

Signature of Patient: ____ Date: _____________