



Authorization to Release/Discuss Medical Information

Patient: _____

I hereby authorize the associates of Colorado HealthQuest to release and/or discuss information regarding medical treatment of me with my other health care providers.

I hereby hold harmless the associates of Colorado HealthQuest and Colorado HealthQuest for any and all results which may occur due to the release and/or discussion of my medical treatment with my other health care providers.

Date: _____

Signature of Patient