

AGUIRRE SPECIALTY CARE

AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____ Date of Birth _____

Name & Address of Physician/Facility Sending Records

I, _____, hereby authorize the above-named physician/facility to release my medical records including specifically the following:

- | | |
|---|--|
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Special Diagnostic Reports (EKG, EEG, etc.) |
| <input type="checkbox"/> Psychiatric Notes | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> History/Physical | <input type="checkbox"/> Other _____ |

to Aguirre Specialty Care at 9800 Mt. Pyramid Ct., Suite 300, Englewood, CO 80112 or by fax at 303-322-0772.

The information is needed for treatment purposes.

This authorization is valid for a period of 90 days from the date signed. A facsimile or photocopy of this authorization shall be considered as valid and effective as the original.

I have read and understand this Authorization to Receive Medical Records and have voluntarily and knowingly signed such consent.

Signature

Date