AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Patient Name:_____

Social Security #: _____ Date of Birth _____

Name & Address of Physician/Facility Sending Records

Name of Physician:_____
Phone Number:_____
Office Fax Number:_____
Address of Physician:_____

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

____ Laboratory Reports
____ Pathology Reports
____ Progress Notes
____ Psychiatric Notes
____ History/Physical
____ Operative Reports
____ Radiology Reports
____ Special Diagnostic Reports (EKG, EEG, etc.)
____ Discharge Summary
____ 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