OSCAR A. AGUIRRE, MD
(303) 322.0500

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:

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

To: Oscar A. Aguirre, MD
11953 Lioness Way
Suite 101
Parker, CO 80134
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