

Consent To Receive Medical Records

Patient Name _____

Date Of Birth _____

I hereby request transfer of the above patient's medical records:

From: _____

To: Midash Pediatrics
13721, Rice PL, Aurora,
CO 80015.
Ph: 303-818-3201

Reason for Request: ___ Permanent Transfer to New Provider

 ___ Consultation with: _____

 ___ Other: _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance abuse, HIV, psychiatric disorders, sexually-transmitted diseases, etc., herein excepted _____

Please include: ___ All medical records OR (check all that apply):

___ Growth chart, immunizations, History, and Physical ___ Medication List ___ Laboratory Reports

___ Radiology Reports ___ EKG Other: _____

Date range: _____ to _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in six months from the date signed.

Signature (patient if over 18 or parent/guardian)

Date

Patient relationship

Contact number

Olukemi Akinrinola, MD

13721 E Rice Place, Aurora. *Colorado 80015 *Phone: 303-818-3201