Hui Olakino
FAMILY MEDICINE

Medical Records Release

Patient Name: ____

Address ____
Street City State ZIP

Home phone ________________________ **Work phone** ______________________

Date of BIRTH: (Month/ Day/ Year): ____________________________

Please transfer my medical records as follows:

From:
Bianca Bryant-Greenwood MD
3700 Quebec St #100 PMB 141
Denver, CO 80207

To:
Name:______________________________________
Address:____________________________________
City/State/Zip:_______________________________
Phone: (________)____________________________

Records to be released:
____: Complete medical record
____: Imaging reports
____: Updated problem list
____: Laboratory results
____: Current medication list
____: Other (Please specify below)

____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.
Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.
_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate 90 days after the release has been received by the office.

____
Signature Print Name

Date Release Signed:________/________/________