CHILDREN'S ORTHOPEDIC CENTER

SUSAN ATKINS, M.D.

1011 Hioaks Rd.

Richmond, VA 23225-4040

Phone: (804) 272-0726

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO DR. ATKINS

Date _____

Patient Name _____

Birthdate _____

Parent/Legal Guardian Name _____

Relationship to patient _____

Please forward the following medical records to Dr. Susan Atkins

1011 D Hioaks Road, Richmond VA 23225, or fax to _____

Office Notes _____

Hospital Discharge Summary Operative Report(s) XRay report(s)

MRI report All radiologic/nuclear medicine studies All labwork

Consult Note Cardiac, Genetic, Rheumatology, Orthopedic, Neurolog , Neurosurgery

Endocrinology, Pediatric Surgery, Pediatric, Other _____

Medication list/allergies

Thank you. Should you have any questions, feel free to contact our office at 272-0726.

Unless otherwise specified, this release is valid for 12 months from date of parent/guardian signature. Signature affirms that parent is the legal representative for the above patient.

Parent/Guardian Signature _____ Date _____