AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby request and authorize the release of my personal health information to the following health organizations and medical professionals:

Injury Care Network, L.L.C	**Rehabilitation Services, L.L.C**
Medical Doctors	William Miller, M.D.
Jon Shick, D.O.	**Movement Dynamics Physical Therapy, P.C.**
Bethany Wallace, D.O.	Shawna Roberts, PT, M.S.P.T
Nurse Practioner	Jennifer Ivey, PT, M.P.T
Daniel Hammond, N.P., D. C.	Elizabeth Ford, PT, D.P.T
Neurologist	Paige Rygg, PT, D.P.T
Alexander Zimmer, M.D.	Melissa Kliem, PT, D.P.T
Neuropsychologists	Jessica Stepanian, PT, D .P.T
Georganne Bley, Ph.D.	**Synergy Chiropractic Clinic, P.C.**
Judith Holland, Ph.D., Traumatologist	Bruce Latta, D.C.
Psychologists	Wayne Hoffman, D.C.
Ron Schwenkler, M.A.,LPC	Gregory Ingram, D.C.
Acupuncturists	Richard Lewellen, D.C.
Kyle Gill, M.S.O.M.,L.Ac.	Daniel Sigars, D.C.
Sandra Shindoll L.Ac.	
Podiatrists	
Michael Schneider, D.P.M.	
Neuro-Optometrist	
Edwin Manniko, O.D.	

☐ **AURORA OFFICE**	☐ **THORNTON OFFICE**
14111 E. Alameda Avenue Suite 200 Aurora, CO 80012 Phone: (303) 343-1357 | Fax: (303) 343-3036	8515 Pearl Street Suite 100 Thornton, CO 80229 Phone: (303) 630-0400 | Fax: (303) 630-0405

Purpose: _____ Continuation of Care
Treatment Dates: _____/_____/_____ to the present.
Treating Facility: _____
Phone Number: _____
Fax Number: _____
STAT:

Please send all records, including diagnostic studies, such as X-Rays, CT's, MRI's, blood work, etc. He/She was seen at your facility for injuries sustained in an automobile accident on or about: _____/_____/_____.

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization will expire in 365 days**. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected.

Other Condition: A copy or facsimile of this form with my signature may be used with the same validity as the original.

Please send to the fax number selected above. Thank you.

Name of Patient: _____
Patient's Date of Birth: _____/_____/_____
Social Security No.: _____-_____-_____
Date of Injury: _____/_____/_____
Treatment Date: _____/_____/_____ **to present.**

Patient's Signature: _____ Date: _____/_____/_____