SYNERGY
HEALTH PARTNERS

# 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:

| ☐ AURORA OFFICE | ☐ THORNTON OFFICE | ☐ DENVER OFFICE |
|---|---|---|
| 14111 E. Alameda Avenue<br>Suite 200<br>Aurora, CO 80012<br>Phone: (303) 343-1357 \| Fax: (303) 343-3036 | 8515 Pearl Street<br>Suite 100<br>Thornton, CO 80229<br>Phone: (303) 630-0400 \| Fax: (303) 630-0405 | 1250 S. Sheridan Blvd.<br>Denver, CO 80232<br>Phone: (303) 927-7119 \| Fax: (303) 568-9331 |

**Injury Care Network, L.L.C**

Medical Doctors
- Jon Shick, D.O.
- Bethany Wallace, D.O.

Nurse Practioner
- Kerrie Beyer, MSN, APRN, F.N.P

Neuropsychologists
- Georganne Bley, Ph.D.
- Judith Holland, Ph.D., Traumatologist

Psychologists
- Ron Schwenkler, M.A.,LPC
- Audra Mitchell, Biofeedback

Acupuncturists
- Kyle Gill, M.S.O.M.,L.Ac.
- Ignacia Genco L.Ac.

Podiatrists
- Michael Schneider, D.P.M.

Neuro-Optometrist
- Edwin Manniko, O.D.

**Rehabilitation Services, L.L.C**
- William Miller, M.D.,M.P.H.
- Veronica Reza, F.N.P.

**W. Rafer Leach M.D.**

**Movement Dynamics Physical Therapy, P.C.**
- Shawna Roberts, PT, M.S.P.T
- Elizabeth Ford, PT, D.P.T
- Emily Gee, PT, D.P.T, FYT
- Kacper Kazibut, PT, D.P.T
- Melissa Kliem, PT, D.P.T
- John Phillips, PT, D.P.T., CSCS
- Eva Steiner, PT, D.P.T

**Synergy Chiropractic Clinic, P.C.**
- Bruce Latta, D.C.
- Kevin Duncan, D.C.
- Gregory Ingram, D.C.
- Greg Karraker, D.C.
- Richard Lewellen, D.C.
- Daniel Younger, D. C.

**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: _____