WESTERN ORTHOPAEDICS, P.C.

1830 FRANKLIN STREET, SUITE 450, DENVER, COLORADO 80218 • PHONE: (303) 321-1333 • FAX: (303) 321-0620

AUTHORIZATION FOR CONTINUITY OF CARE CORRESPONDENCE

I hereby authorize my medical provider(s) at Western Orthopaedics, P.C., to correspond with the person(s) listed below for coordination of my care.

Patient Name:_____ **Account#:**_____
(Please Print)

PRIMARY CARE DOCTOR (Please Print) **None to list** (Please circle)

NAME: _____ MD, DO, (Circle One)
First Last

ADDRESS: _____

_____
City State Zip

PHONE: _____

FAX: _____

ATTORNEY (Please Print) **None to list** (Please circle)

NAME: _____
First Last

ADDRESS: _____

_____
City State Zip

PHONE: _____

FAX: _____
Please fill out Medical Record Release attached

REFERRING PROVIDER (Please Print) **None to list** (Please circle)

NAME: _____ MD, DO, Work Comp Dr., PT, Other (Circle One)
First Last

ADDRESS: _____

_____
City State Zip

PHONE: _____

FAX: _____

OTHER (Please Print) **None to list** (Please circle)

NAME: _____
First Last

ADDRESS: _____

_____
City State Zip

PHONE: _____

FAX: _____
Please fill out Medical Records Release attached

I understand that I may revoke this authorization at any time by contacting Western Orthopaedics, P.C. at the above address, Attention: Medical Records Officer. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information may have already acted in reliance on this authorization.

I certify that this request has been made voluntarily.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness/Legal Guardian Date

If patient is unable to sign, please document reason below: