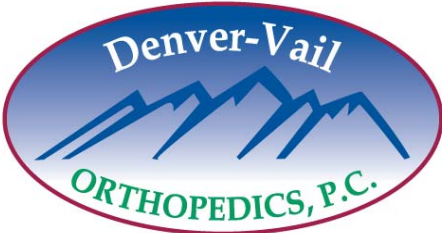


Authorization for Release of Information



8101 E. Lowry Blvd., Suite 260  
Denver, CO 80230  
303-214-4500

11960 Lioness Way, Suite 270  
Parker, CO 80134  
720-974-5220

Patient Name: \_\_\_\_\_  
Last First M.I.

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

I hereby authorize: **Denver-Vail Orthopedics, P.C.**  
\_\_\_\_\_  
\_\_\_\_\_

to furnish any and all information with respect to any illness or injury, medical history, consultation or treatment and copy of all medical records and X-rays

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_  
Date

Witness: \_\_\_\_\_  
Date