



**DENVER-VAIL ORTHOPEDICS PC  
AUTHORIZATION FOR RELEASE OF INFORMATION**

\_\_\_\_\_ Lowry Medical Center  
8101 E. Lowry Blvd., Suite 260  
Denver, Colorado 80230  
(303) 214-4500 Fax (303) 214-4570

\_\_\_\_\_ Lincoln Medical Center  
11960 Lioness Way, Suite 270  
Parker, Colorado 80134  
(720) 974-5200 Fax (720) 974-5239

Request Date: \_\_\_\_\_

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

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

I hereby authorize: Denver Vail Orthopedics PC  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Completed by Medical Records \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_