JOHN A. BAKER, M.D.
JAMES R. SACKETT, M.D.
DANIEL E. COOPER, M.D.
PAUL C. PETERS, M.D.
ANDREW B. DOSSETT, M.D.
EUGENE E. CURRY, M.D.
DANIEL A. WORRELL, M.D.
KURT J. KITZIGER, M.D.
ANDREW L. CLAVENNA, M.D.
MARK S. MULLER, M.D.
TODD C. MOEN, M.D.

CARRELL CLINIC
A Division of OrthoLoneStar

ORTHOPAEDIC SURGERY & SPORTS MEDICINE

J. CARR VINEYARD, M.D.
M. MICHAEL KHAIR, M.D.
WILLIAM R. HOTCHKISS, M.D.
J. FIELD SCOVELL, III, M.D.
JASON S. KLEIN, M.D.
BRIAN P. GLADNICK, M.D.
BRADFORD S. WADDELL, M.D.
WILLIAM A. ROBINSON, M.D.
HOLT S. CUTLER, M.D.
TYLER YOUNGMAN, M.D
JUSTIN M. CARDENAS, M.D

Dear friends and patients:

This is a bittersweet letter for me. The time has come for me to close this chapter of my life.

For nearly 40 years I have been blessed to be a part of the Carrell Clinic. Over the years I have been blessed to work with the best doctors and at the finest facilities.

The biggest blessing, however, has been the privilege and opportunity to have your confidence in me to help you work through various injuries and ailments as they arise. I can't imagine a more fulfilling and rewarding professional career. Some of you I have known for years and others I have met more recently. I wish that I could personally thank each and every one of you. You have no idea how much you have enriched my life. I can only hope that I have been able to help you in some way.

I know that I leave your ongoing care and needs in good hands, and we will do everything we can at the Carrell Clinic to maintain continuity of your care in every way possible. I will maintain office hours through February and will be actively participating in the transfer of your care.

As with everything, there is a beginning and an end; neither of which can sometimes be seen until the time is at hand.

So now we turn the page. Please know that I will miss our visits and discussions more than anything. Thank you for your patience and understanding with me as we have worked through your problems. Hopefully our paths will cross down the road.

Most gratefully,

John A Baker M.D.

Note: If you wish to see a physician outside of our practice, you can request a copy of your medical records by completing the attached medical records release form. Those records will remain at The Carrell Clinic. Please contact our office or visit our website to obtain a copy of your records. Your records can only be released after we receive your authorization.

9301 N. Central Expwy, Tower I, Suite 500 • Dallas, Texas 75231
3800 Gaylord Pkwy, Suite 710 • Frisco, Texas 75034
Phone (214) 220-2468 • Fax (214) 720-1982
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____(optional)

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address:_____

This information may be disclosed TO and used by the following individual or organization:

_____ Address:_____

For the purpose of:_____

Please release the following: {Note: list not required by HIPAA}

___Entire Record

or:
- ___Problem List
- ___Progress Notes
- ___History/Physical Exam
- ___Medication List
- ___Immunization Record
- ___List of Allergies
- ___X-Ray/Imaging Reports-from (date)_____ to (date)_____
- ___X-Ray Films
- ___Laboratory Results-from (date)_____to (date)_____
- ___EKG Reports
- ___Genetic Testing Information
- ___Other Diagnostic Reports (Specify)_____
- ___Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____*(insert privacy officer or other office or individuals name or contact information)*

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

Date request completed_____ # pages copied_____ Reviewed only_____

Charges $_____ Cash_____ Check #_____ Initials_____

* [All articles and any forms, checklists, guidelines and materials are for generalized information only, and should not be used or referred to as primary legal sources, nor construed as establishing medical standards of care. They are intended as resources to be selectively used and always adapted- with the advice of the organization's attorney- to meet state, local, individual organizations and department needs or requirements. It is distributed with the understanding that neither Texas Medical Liability Trust's Risk Management Department nor Texas Medical Liability Trust is engaged in rendering legal services.]