TEXAS PANHANDLE
ORTHOPEDICS

1301 S Coulter St, Suite 103
Amarillo, TX 79106

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www.TexPanOrtho.com

May 31, 2021

Dear Patient,

I am very sad to inform you that I will be closing my practice, Texas Panhandle Orthopedics, on July 2, 2021. My daughter was recently diagnosed with a neurologic condition, and my wife and I have decided to move closer to her physicians. I will be joining an employed orthopedic practice at Methodist Hospital Stone Oak in San Antonio, Texas. My last scheduled patient appointments will be on June 30, 2021.

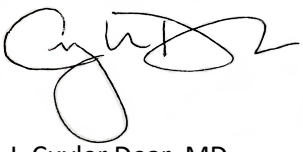
I have greatly enjoyed being back in the Texas Panhandle; reconnecting with friends, being closer to family, and making many new friends and colleagues along the way. As I have said many times over the past few weeks, I am truly sorry for the inconvenience this causes you. It has been an honor to care for you, and I only ask for your understanding as I do what I feel is necessary for my family.

Presently and through July of 2021, your medical records will be maintained in this office in accordance with Texas State Board of Medical Examiners Medical Records chapter 165.1(b) and 165.5(a). If you would like a copy of your medical records, please contact us at (806) 502-6570 or by mail or in person at 1301 S Coulter St, Suite 103, Amarillo, Texas, 79106. We have attached a release of medical records form for your convenience. Please include this form with any request for medical records.

Starting in August of 2021, James R. Parker, MD, a board-certified orthopedic surgeon, will be custodian of your medical records. He has also graciously agreed to provide follow-up care for my patients. If you would like to make an appointment with Dr. Parker for your orthopedic care, or, starting August 1, 2021, if you would like a copy of your medical records, you may contact his office at (806) 350-2663, or by mail or in person at 7000 SW 9th Ave, Amarillo, Texas, 79106. Dr. Parker has been providing comprehensive orthopedic care to the Texas Panhandle for 15 years, and I greatly appreciate his willingness to take excellent care of my patients.

Once again, thank you for your understanding, and please contact me if you have any questions or concerns.

Sincerely,



J. Cuyler Dear, MD

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

THIS FORM MUST BE FILLED OUT COMPLETELY

Patient's Name: _____ SS#: _____-_____-_____ DOB: _____ / _____ / _____

Address: _____

I authorize J. Cuyler Dear, MD, and Texas Panhandle Orthopedics, PLLC, to disclose my individually identifiable health information, as described below, which may include information concerning communicable diseases including but not limited to Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by the federal and state privacy regulations. I understand that my healthcare and my payment of my healthcare will not be affected if I do not sign this form.

INFORMATION RELEASED TO:

_____

_____

_____

_____

INFORMATION RELEASED FROM:

J. Cuyler Dear, MD
Texas Panhandle Orthopedics, PLLC
1301 S. Coulter St, Suite 103
Amarillo, TX 79106
P: (806) 502-6570 F: (806) 502-6567

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

__ Clinical Notes (Consults, H&P, Operative Notes, Progress Notes)
__ Laboratory Results and Pathology Reports
__ Imaging Reports (Radiologist interpretation of MRIs, CTs, Ultrasounds)
__ CD consisting of Xray Images Taken in Our Office (does not include radiologist interpretation)
__ Other (Please Specify) _____

REASON OR PURPOSE OF RELEASE (CHECK ALL THAT APPLY):

___ Continued Patient Care ___ Insurance Claim/Application ___ Attorney/Legal ___ Personal Use

___ Disability Determination ___ Social Security ___ Other: _____

I understand that the informtation released is for the specific purpose stated above. Any other use of this information without written consent is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the date of my signature unless otherwise specified.

_____ _____ / _____ / _____

Signature of Patient, Legal Guardian, or Patient's Legal Representative **Date**

(Please attach supporting documentation for legal representative)

---------- **FOR OFFICE USE ONLY** ----------

Records picked up: _____ Records Sent: _____ Date: ____ / ____ / _____ Initials: _____