Robert Sutherland, M.D.
Interventional Spine Associates, P.A.
700 Olympic Plaza, Suite 404
Tyler, Texas 75701
(903) 593-1738

July 1, 2020

Dear Patient:

This letter is to inform you that I am closing my medical practice at Interventional Spine Associates, P.A. in Tyler, Texas. This becomes effective on July 2, 2020. I will continue to see patients at Interventional Spine Associates through July 30, 2020.

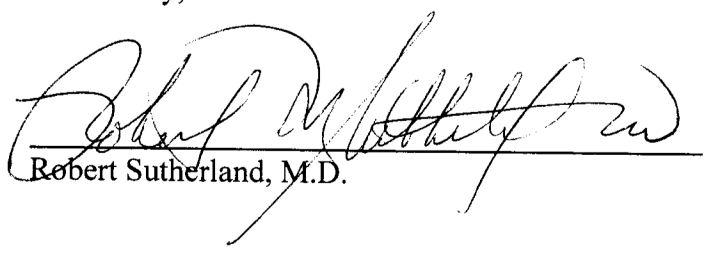
As of August 1, 2020, Dr. Harold Bolnick, with UTHC will be taking over medication management and Dr. David Olvera with UTHC will be taking over procedure patients.

Each will be available for appointments, and you may transfer your medical records to them or another medical provider of your choosing. The address for Dr. Bolnick and Dr. Olvera is 700 Olympic Plaza Circle #850, Tyler, TX 75701; Telephone (903) 594-2836.

If you have any problems in transferring your records, please contact the office manager at my former office, as listed above. Also, for your convenience, we have enclosed an Authorization to Release Medical Records for you to complete and return to our address above. This will facilitate the timely transfer of records to Dr. Bolnick or Dr. Olvera.

I would like you to know what a great honor and privilege it has been to serve you. I sincerely apologize for any inconveniences you may experience as a result of my relocation, and I am and will continue to endeavor to keep those inconveniences to a minimum. Thank you again for allowing me to provide for your health care needs.

Sincerely,



Robert Sutherland, M.D.

Enclosure

Interventional Spine Associates

Robert M. Sutherland, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law, Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness/psychological conditions, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and I authorize the release of all such records.

I authorize the following facility/provider to release information as specified below:

Facility/Provider to release information _____

Information to be released:

☐Complete Record

☐Records of care for the following dates: _____ to _____

☐Other (Please Specify): _____

Purpose of disclosure:

☐Medical Care ☐Attorney ☐Insurance ☐Social Security/Disability

☐Other (Please Specify): _____

This information shall be released to:

I understand that I have the 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 Medical Records Department. 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.

A photocopy of this authorization is as valid as the original. This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless other wise specified by date, event, or condition as follows.

Patient Name (Printed) _____ Patient Signature _____ Date _____

700 Olympic Plaza Circle Suite 404 Tyler TX 75701
Phone: 903-593-1738 or 866-622-7284
Fax: 903-596-7852 or 903-593-4480