


<b>Patient:</b>		<b>Birth Date:</b>		<b>Social Security No. (optional):</b>	
<b>Provider:</b> 		<b>Recipient's Name:</b>			
<b>Provider's Address:</b> <b>Tulsa Bone &amp; Joint Associates, P.C.</b> 4802 South 109th East Avenue Tulsa, Oklahoma 74146 Ofc: 918-392-1400 Fax: 918-392-1401		<b>Address:</b>		<b>Area Code and Telephone #:</b>	
		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Purpose of Request</b>	<b>Cost for Copies*</b>	<b>Purpose of Request</b>	<b>Cost for Copies*</b>	<b>Purpose of Request</b>	<b>Cost for Copies*</b>
<input type="checkbox"/> Self, Employment or Other	First page	<input type="checkbox"/> Physician	No charge	<input type="checkbox"/> Film Copies of X-rays	\$5.00
<input type="checkbox"/> Attorney	\$1.00 + Each	<input type="checkbox"/> Medical Claims Process	No Charge	<input type="checkbox"/> MRI on CD	\$2.00
<input type="checkbox"/> Insurance Company	addl page .50	<input type="checkbox"/> Disability	\$15.00	*For mailing - actual postage charged	
<b>Description of Information to be Used or Disclosed (Please check and specify dates)</b>					
<b>Description</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>
<input type="checkbox"/> All medical record		<input type="checkbox"/> MRI Report		<input type="checkbox"/> Copies of MRI	
<input type="checkbox"/> Admission Form		<input type="checkbox"/> MRI Report		<input type="checkbox"/> Charge Statement	
<input type="checkbox"/> Office Notes		<input type="checkbox"/> X-ray Report		<input type="checkbox"/> Other:	
<input type="checkbox"/> Operative Report		<input type="checkbox"/> Copies of x-rays		<input type="checkbox"/>	
<b>I acknowledge, that the information authorized for release may indicate the presence of a communicable or noncommunicable disease.</b>					
<b>This Authorization:</b>					
1. Will expire in 12 months or _____. 2. I understand that I have the <b>right to refuse to sign this authorization</b> and that my signature is not required for obtaining treatment or reimbursement for treatment, unless the sole purpose of this authorization is to determine payment of a claim or benefit. 3. I understand that I have a <b>right to receive a copy</b> of this Authorization. 4. I understand that I have the <b>right to revoke this authorization in writing</b> at any time. To obtain information on how to revoke this authorization, contact the medical records department. I am aware that my revocation will not be effective as to uses and /or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. 5. I understand that I have the <b>right to inspect or copy the health information</b> I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Clerk.					
<b>WARNING:</b> We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information of records may occur by such party.					
<b>Release:</b> I release Tulsa Bone & Joint Associates, P.C., its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.					
<b>Patient's Signature:</b>		<b>Date:</b>		<b>Time:</b>	
<b>Person Authorized to Sign for Patient - Signature:</b>		<b>Relationship to Patient:</b>		<b>Date / Time:</b>	