Medical Records Request

Patient:	Birth Date:	Social Security No. (optional):
Provider: Tulsa Bone & Joint Associates	Recipient's Name:	
Provider's Address: **Tulsa Bone and Joint Associates, P.C.** 4802 S. 109th E. Ave Tulsa, Oklahoma 74146 Ofc: 918-392-1400 Fax: 918-392-1401	Address: City: State: Zip: Area Code and Telephone # Email Address:	

Purpose of Request	Cost of Copies*	Purpose of Request	Cost of Copies*	Purpose of Request	Cost of Copies*
☐ Self, Employment or Other	**ASK**	☐ Physician	No Charge	☐ Film Copies of X-Rays	
☐ Attorney	**FOR**	☐ Medical Claims Process	No Charge	☐ MRI on CD	
☐ Insurance Company	**PRICING**	☐ Disability	$5 per page	*For mailing - actual postage charged	

Description of Information to be Used or Disclosed (Please check and specify dates)

Description:	Date(s) / Body Part	Description:	Date(s):	Description:	Date(s):
☐ All Medical Records - X-ray Separate		☐ MRI Report		☐ Copies of MRI	
☐ Admission Form		☐ X-ray Report		☐ Charge Statement	
☐ Office Notes		☐ Copies of X-Rays		☐ Other:	
☐ Operative Reports					

I acknowledge that the information authorized for release may indicate the presence of a communicable or noncomminicable disease.

This Authorization:

1. **Will expire in 12 months or _____.**
2. I understand that I have the **right to refuse to sign this authorization** 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 **right to receive a copy** of this Authorization.
4. I understand that I have the **right to revoke this authorization in writing** 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 **right to inspect or copy the health information** 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.

WARNING: 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.

RELEASE: 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.

Patient's Signature: **Date:** **Time:**

Person Authorized to Sign for Patient- Signature: **Relationship to Patient:** **Date/Time:**