TULSA PAIN
CONSULTANTS

Phone: (918) 742-7030 Fax (918) 742-9958

AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name (please print legibly): _____Date of Birth:_____

Account Number: _____ Today's Date:_____

I hereby authorize Tulsa Pain Consultants to release my medical records to:

_____
Name of Facility and/or Person Receiving Records

Address of Facility or Person Receiving Records
_____
_____
_____

Phone number: _____ Fax Number: _____

Method of Delivery: ❒ Mail ❒Fax ❒Pick up at office

Release Records as follows: ❒Last 2 years ❒Last 5 year ❒All Records
❒MRI (must select to get MRI) ❒: Other_____

Purpose of Release: ❒Self ❒Another Doctor ❒Insurance ❒Other

By signing this form, I authorize the use or disclosure of my medical records for the purpose listed above. I have a right to receive a copy of this authorization. I have the right to withdraw permission for this authorization. I acknowledge I must do so in writing. I understand doing so does not restrict information that may have already been shared based on the authorization. My medical information may indicate that I have a communicable and/or non-communicable disease and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse. Unless revoked, this form expires one (1) year from the date it was signed.

_____
Signature of Patient or Legal Representative

TPC USE ONLY Description of records: ❒ OV ❒ Procedures ❒ MRI ❒ UDS

❒ other_____

Date(s) of service: _____ ❒ Complete Chart (NP to Current)

❒Office Pickup ❒Mailed ❒Faxed

Completed by:_____ Date:_____