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

_____: 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 of service: ______________To _______________ ❒ Complete Chart (NP to Current)

Printed by: ____________________________ Date:____________________________

Records given by: ___________________________ Date: ________________________