



Medical Record Request

Please Print Clearly

Patient Name:

Date of Birth:

Physician Records

Please Check Box

O. David Taunton Jr., M.D. ☐

B. Todd Drury, M.D. ☐

Katherine C. Bartush, M.D. ☐

Howard W. Harris, M.D. ☐

Nathan B. Haile, M.D. ☐

Michael L. Nguyen, M.D. ☐

Paul A. Tavakolian, M.D. ☐

Jacob D. Taunton, D.O. ☐

Record Request

Last Office Notes: ☐

All Records: ☐

MRI Report: ☐

Body Part:

MRI Date:

	/		/	
Month		Date		Year

Radiology Images ☐

There is an \$8.00 charge for all discs/images

Record Receiving

Discs cannot be faxed or emailed

IN OFFICE PICK UP ☐

Phone:

Mid-Cities ☐

Alliance ☐

FAX ☐

Fax Number:

Name:

Attention:

Phone:

EMAIL ☐

Name:

Email Address:

- By submitting this form, you agree to the **\$25.00 charge for all medical records** and the **\$8.00 charge for all discs/imaging** to be paid in full to Texas Orthopedic Specialists -Medical Records Department.
- By submitting this form, you agree that Texas Orthopedic Specialists has the right to release medical records for the patient listed above by means of selection (in person, by fax, or through email) on this form.

☐ I Agree

Signature:

Date:

Medical Records Fax: 817-510-0188

Medical Records Phone: 682-428-4221

817-540-4477

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