Medical Record Request

Please Print Clearly

Patient Name: _____ Date: _____

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 ☐

Name: _____ Fax Number: _____

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: _____

Bedford Medical Records Phone: 817-510-4020 Medical Records Fax: 817-510-0188 Alliance Medical Records Phone: 682-428-4221