Request for Medical Records

Patient Name:_____

Date of Birth:_____

Please circle physician:

Dr. Taunton/ Dr. Harris/ Dr. Nguyen/ Dr. Drury/ Dr. Suttle/ Dr. Haile/ Dr. Tavakolian

Which records are you requesting?
Last office note
MRI report
All records
Other: _____

Do these records include radiology images? (Please circle): MRI / Xray

Please check which option to obtain below for your records:

_____ Fax (please provide below information; radiology images cannot be sent electronically)

Name:_____Fax :_____

_____ Pick- up at our office (provide # to contact when ready) _____

_____ Email (provide email to end to) _____
(Radiology images cannot be sent electronically)

By signing below, I am authorizing the release of my records by the above noted means and is intended only for the use noted above.

Please note that there is an $8.oo fee for radiology images to be printed onto a CD.

Patient Signature:_____

Date:_____

Texas Orthopedic Specialists PLLC
2425 Highway 121
Bedford, TX 76021
Phone: 817-540-4477
Fax: 817-540-5633