Tulsa Bone&Joint Associates

NOTICE: As of January 2. 2005, we will need to obtain an updated Medical Release Form before medical records or medical information can be released.

Authorization and Consent to Release All Medical Records and Medical Information

I, _____, being competent and duly authorized, do willfully and voluntarily authorize the release of all medical records and medical information pertaining to _____, without restriction to:

_____

_____

_____

_____

I further understand and acknowledge that the information authorized for release could be considered information about communicable and venereal diseases which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Patient (Legal Guardian) Signature: _____

Date of Birth: _____ Social Security Number: _____

Date: _____

If patient is a minor:

Name: _____

Date of Birth: _____ Social Security Number: _____

Date: _____

4802 S. 109th E. Ave.
Tulsa, Oklahoma 74146
Office (918) 392-1404
Fax (918) 392-1401