



MEDICAL RECORDS REQUEST FORM

Submit by Fax: 1-800-991-6487 | Email: records@twcheals.com

Mail: 1900 NW Expressway, Suite 800 Oklahoma City, OK 73118

IMPORTANT: A signed authorization is required before records can be released. Requests missing required fields may be delayed. Please print clearly in ink. All fields marked with an asterisk (*) are required.

SECTION 1 — PATIENT INFORMATION

Patient Last Name *

Patient First Name *

Middle Name / Initial

Date of Birth * (MM / DD / YYYY)

Current Mailing Address * (Street, City, State, ZIP)

Phone Number *

Email Address

Last 4 Digits of SSN (for identity verification)

State(s) Treated * (OK / KS / MO / AR / TX)

SECTION 2 — RECORDS REQUESTED

Date(s) of Service — From * (MM / DD / YYYY)

Date(s) of Service — To * (MM / DD / YYYY or 'Present')

Type of Records Requested (check all that apply):

- Complete Medical Record *all notes, encounters, lab results, imaging, Operative / Procedure Reports*
- Wound Care / Treatment Notes Only
- Lab Results / Diagnostic Reports
- Imaging / X-Rays / Photographs
- Referral Documentation
- Billing Records / Itemized Statement
- Other — Please specify:

Other Record Description

Preferred Format (check one):

- Electronic / PDF (preferred)
- Paper Copy (mail)
- Transfer to Provider (below)

SECTION 3 — RELEASE TO (Complete only if transferring to another provider)

Receiving Provider / Facility Name

Provider Address *(Street, City, State, ZIP)*

Provider Fax Number

Provider Phone Number

Provider Email Address (if available)

Attention / Department (if applicable)

SECTION 4 — PURPOSE OF REQUEST

Reason for Request (check one):

- | | |
|--|---|
| <input type="checkbox"/> Continuity of Care / New Provider | <input type="checkbox"/> Social Security / Disability Claim |
| <input type="checkbox"/> Personal Records | <input type="checkbox"/> Workers' Compensation |
| <input type="checkbox"/> Insurance / Billing Purpose | <input type="checkbox"/> Research (requires additional authorization) |
| <input type="checkbox"/> Legal / Attorney Matter | <input type="checkbox"/> Other: _____ |

Fee Waiver Notice: Patients requesting records solely to support a Social Security Administration (SSA) disability claim (Title II, XVI, or XVIII) may be entitled to one free copy under Texas law (Tex. Health & Safety Code § 241.154) and HIPAA fee guidance. Please indicate SSA / Disability Claim above if applicable.

SECTION 5 — AUTHORIZED REPRESENTATIVE (Complete only if not the patient)

Relationship to Patient (check one):

- | | | |
|--|--|---|
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Medical Power of Attorney | <input type="checkbox"/> Executor / Estate Rep. |
| <input type="checkbox"/> Parent of Minor | <input type="checkbox"/> Attorney of Record | <input type="checkbox"/> Other: _____ |

Representative Last Name *

Representative First Name *

Representative Phone Number

Representative Email Address

Mailing Address of Representative *(Street, City, State, ZIP)*

Required Documentation: A copy of the legal documentation establishing your authority (e.g., POA, guardianship order, letters testamentary) and a valid government-issued photo ID must accompany this request.

Documentation enclosed: Yes No — will submit separately

SECTION 6 — PATIENT AUTHORIZATION & SIGNATURE

I hereby authorize Total Wound Care to release the medical records described above. I understand that:

- This authorization is voluntary. I may revoke it in writing at any time, except where records have already been released.
- Records released pursuant to this authorization may no longer be protected under HIPAA once received by the designated party.
- Requests will be processed in accordance with applicable federal law (HIPAA, 45 C.F.R. § 164.524) and state law, including 76 O.S. § 19 (OK), RSMo § 191.227 (MO), A.C.A. § 16-46-106 (AR), Tex. Health & Safety Code § 241.154 (TX), and applicable Kansas regulations.
- Reasonable fees may apply where permitted by law. I may be required to pay applicable fees before records are released, unless a fee waiver applies.
- This authorization expires one (1) year from the date signed below, unless I specify an earlier date.

Expiration Date (if earlier than one year): _____

Signature of Patient or Authorized Representative *

Date * (MM / DD / YYYY)

Printed Name *

Relationship to Patient (if not patient)

FOR OFFICE USE ONLY

Date Received: _____	Date Released / Fulfilled: _____	Processed By: _____
Fee Assessed: _____	Fee Waiver Applied: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> SSA Waiver	Method of Release: <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Portal
Notes: _____		

This form is governed by HIPAA (45 C.F.R. § 164.524), 76 O.S. § 19 (OK), RSMo § 191.227 (MO), A.C.A. § 16-46-106 (AR), Tex. Health & Safety Code §§ 241.103 & 241.154 (TX), and applicable Kansas regulations.