Integrative Medical Solutions
Medical Record Request Form

Patient Name:_____ Date of Birth:_____
Patient SSN:_____ Patient Phone:_____

Please Obtain Information From_____
_____
_____
_____

Please Send Information To: Integrative Medical Solutions
Dr. Scott Waugh, Dr. Ashlee Waugh, Wendy Parks, ARNP-CNP, Cassie Davis, ARNP-CNP
65 S Saints Blvd, Edmond, OK 73034
(405)348-2323 phone **(405)348-2325 fax**

Information to be released:

- ❑ Completed Medical Records
- ❑ The Last Year of Medical Records (chart notes, labs, radiology)
- ❑ Itemized Bill
- ❑ Other:_____

- I understand that I do not have to sign this to receive medical treatment.
- I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely.
- I understand that the information authorized for release may include records which may indicate the presence of communicable or non-communicable disease. By state law you must be advised that information you authorize for release may include information about disease processes that are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as AIDS.
- I understand that information pursuant to this authorization may include alcohol and/or drug abuse records protected under federal and or state law.
- I understand my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.
- I understand that to cancel this authorization, I must send a written request to IMS where my medical records are kept.
- I understand that this authorization will automatically expire one year from the date of my signature.
- I understand that there will be no charge for records that are faxed, however any copies made will be .25 per page. By signing below, I give my authorization to use the use of this disclosure of the information identified above, and release Integrative Medical Solutions, its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

Patient Name (printed)_____ Patient DOB_____

Patient Signature_____ Date_____