Dallas Allergy and Asthma Center

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: ________________________________

1. Patient Name:____

   Date of Birth:__________________________________ Phone#:_______________________________

   Persons/organization(s) **providing** the records: **(Complete address/phone #/fax #)**

   ____
   ____
   ____
   ____

   Persons/organization(s) **receiving** the records: **(Complete address/phone #/fax #)**

   ____
   ____
   ____
   ____

   Covering all the periods of care from: _________________________to____________________________

2. Information to be released:

   _______________________ Copy of complete medical records
   _______________________ Excluding information related to HIV testing and/or results
   _______________________ History and Physical
   _______________________ Skin Testing results/RAST results
   _______________________ Pulmonary Function Studies
   _______________________ X-Ray reports
   _______________________ Exact composition of current allergenic extract
   _______________________ Other____

3. Purpose of Disclosure: ____________________to send to insurance company
   ____________________ to send to new family/general physician
   ____________________ to transfer care to a new allergist

4. I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

5. Specification of the date, event of condition upon which this consent expires:

   ____

6. The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

PLEASE NOTE: A $25 FEE WILL BE ASSESSED FOR COPIES REQUESTED FOR PERSONAL MATTERS (i.e. personal copy, life insurance policy and attorney requests)

Signed: ____ Date: __________________________
Patient or Representative

____
Relationship to Patient