MEDICAL RECORDS RELEASE TO AACT

AACT staff member initiating request:

_____

ALLERGY & ASTHMA
CENTER OF TEXAS

Allergy & Asthma Center of Texas
6946 Lebanon Rd. • Frisco, Texas 75034 • (972) 377-9987 Phone • (972) 377-9906 Fax

Authorization for Release of Medical Records

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____ Date of request: _____

I hereby authorize _____ to release medical records to the following facility:
(Physician/Facility Name)

Allergy & Asthma Center of Texas
6946 Lebanon Road
Frisco, Texas 75034
(972) 377-9987 Phone (972) 377-9906 Fax

PURPOSE FOR THIS REQUEST: (Check one) ☐ Changing Physicians ☐ Continuation of Care

☐ Referral ☐ Other (please specify) _____

TYPE OF RECORDS REQUESTED: (Check All That Apply) ☐ All ☐ Labs ☐ Radiology Reports

☐ Allergy Shot Records ☐ Skin Test ☐ Other _____

AUTHORIZATION VALID FOR: (Check one)

☐ This request only.

☐ One year from the date of this authorization **OR** _____. (Insert date)

Initial "I do" or "do not" for each of the following:

I do _____ **do not** _____ consent to the disclosure of information pertaining to psychiatric or psychological evaluation or treatment.

I do _____ **do not** _____ consent to the disclosure of evaluation or treatment of reportable communicable diseases including sexually transmitted diseases and HIV (AIDS).

I do _____ **do not** _____ consent to the disclosures of substance/alcohol abuse evaluation/treatment.

I understand the following:

1. I may revoke this authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization) by sending a written revocation to the health care provider/organization designated above.
2. Any treatment, payment, or my enrollment in any health plan or my eligibility for benefits will not be affect if I do not sign this authorization.
3. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
4. I am entitled to receive a copy of this signed authorization upon my request.
5. There may be a charge for the requested records.

Signature of Patient or Legal Guardian _____ Date _____

Relationship to Patient (if requestor is not the patient) _____