

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