Allergy & Asthma Centres OF THE METROPLEX

PID: _____

Medical Records Release Form

By signing this form, I authorize,

_____

Phone: _____ Fax: _____

to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIVS/AIDS: I consent to the release of any positive or negative test result for HIV or AIDS, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial: _____ Date: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

Release my protected health information to the following person(s)/entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

The reason or purpose for the release of information are as follows:

Printed Patient Name: _____ Date of Birth: _____

Patient/Parent/Guardian Signature: _____

Today's Date: _____

This release will expire (six) months from the date it was signed, unless, it is revoked in writing. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.