Request for Medical Record

Name ____________________________________ DOB__/__/__ Date__/__/__

TO: ____

I hereby authorize the release of all my medical records and test results regarding my diagnosis and treatment. □ Most recent □ In last 3 6 12 months □ Last one on record □ All available record

Please fax below documents to Asthma Allergy Sinus Center 210 888 5851:

□ Allergy skin and blood tests for food/inhalants/insect/drugs

□ Allergy shot record/log in last 3-6 months or the last available

□ Immunotherapy MIX components

□ PFT-pulmonary function testing □ eNO-exhaled nitric oxide testing

□ CT scan sinuses □ CT scan lung □ CT scan other

□ CXR-chest X ray □ X ray neck lateral neck □ X ray other_____________

□ Lab results (CBC+ dif, CMP, TSH, Vit D, immune status panel, other

Please fax if possible as soon as you can requested medical record.

I understand that I may revoke this authorization at any time by notifying the provider's office in writing.

I understand that in compliance with TX State Board of Medical Examiners I will pay a fee of $25.00 for the first 20 pages and $0.50 for each additional page. The fee will be waived if records are requested from medical facility for ongoing care.

I understand that records should be released within two weeks of my request.

I hereby release you, your physician and employees from liability for following this authorization and request.

Thanks for all your help and assistance

Signature ____________________ Legal guardian Signature_____________________

Witness ____________________