TEXAS REGIONAL ASTHMA AND ALLERGY CENTER, L.L.P.

Board Certified specialists in allergy, asthma, immunology, and respiratory disorders
RICHARD A. MAYSE, M.D., RENE ALBERT LEON, M.D., ALI SHAKOURI, M.D., SHARON SETH, M.D. ZACHARY W. MARSHALL, M.D.
900 East Southlake Blvd. Suite 300 Southlake Texas 76092 (817) 421-0770 (817) 421-4759 (Fax)
4312 Heritage Trace Pkwy. Ste 708 Fort Worth, TX 76244 (817) 421-0770 (817) 562-5008 (Fax)
WEBSITE: www.traac.org

Medical Record Request Form

Patient Name: _____ DOB: _____ SSN: _____

This request expires on_____. If left blank, expires 1 year from signing or until revoked in writing.

I authorize you to ***request*** confidential health information about me from the person(s) or entity listed below:

Name: _____
City: _____ State: _____

Phone: _____ Fax: _____

The reason/purpose for this request of information is as follows:

- Transfer of another provider
- Personal File
- Payment of Bill
- Insurance/Work/Second opinion
- Attorney
- Other: _____

Please forward the requested information to:

Texas Regional Asthma & Allergy Center
900 E. Southlake Blvd. Suite 300
Southlake, TX 76092
817-421-0770 (Phone) 817-421-4759 (Fax)

I authorize you 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:

Name: _____
City: _____ State: _____ Zip Code: _____
Fax: _____ Phone: _____
Email:_____

Dates of information to be disclosed: From _____ to _____. If left blank only information from the past two years will be disclosed.

Information to be disclosed:

- All medical records related to: *(Specify condition, treatment, etc.)*_____
- All diagnostic testing related to: *(Specify condition, treatment, etc.)*_____
- All billing records related to: *(Specify condition, treatment, etc.)*_____

I do not want the following information disclosed (as defined by applicable state and federal laws):

- Alcohol/Drug Abuse
- HIV Test Results
- Mental Health/Developmental Disabilities

I understand that there may be a fee associated with the release of my medical records and agree to payment.

_____ _____ _____
Patient/Guardian printed name Patient/Guardian signature Date