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

Board Certified specialists in allergy, asthma, immunology, and respiratory disorders

RENE ALBERT LEON, M.D. ALI SHAKOURI, M.D. SHARON SETH, M.D. ALAYNA POWERS, R.N., FNP-C

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 Release 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 (TRAAC) 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:

Doctors 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