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

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

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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 (TRAAC) 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:

- o Transfer of another provider
- o Personal File
- o Payment of Bill
- o Insurance/Work/Second opinion
- o Attorney
- o 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)

Patient/Guardian printed name	Patient/Guardian signature	Date