

# NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

## PREBYTERIAN OFFICE

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## BAYLOR OFFICE

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## PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS TO OTHER MEDICAL PRACTITIONER

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I authorize North Texas Allergy & Asthma Associates to release my medical information and/or individually identifiable health information to:

\_\_\_\_\_ as may be required or permitted under federal or state law. I further authorize physician to release such information to physicians, hospital, or healthcare providers needing such information to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I also understand that this authorization may be revoked by me by a written and dated notice, except to the extent that disclosure of information has been made prior or receipt of such revocation.

I authorize the use of a copy of this release and consent in place of the original.

Patient Signature: \_\_\_\_\_

If a minor, authorized representative of Patient:

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Information Requested: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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