ALLERGY & ASTHMA CONSULTANTS, L.L.P.
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby authorize the release of information from the medical record of:

Print Name:_____
DOB:_____
Phone Number: _____

FROM: (*Please Check One)*

- ☐ T.S. Painter, Jr., M.D.
- ☐ Edward J. Peters, M.D.
- ☐ Maria G. Gutierrez, M.D.
- ☐ Paul G. Vigo, M.D.
- ☐ Alexander Alvarez, M.D.

Mail To: *(Print Name/Address)*

_____
_____
_____
_____

Phone Number:_____
Fax Number: _____

Please send copies of medical records for the above patient during the time period:
From _____ To _____

Records will include:

1. Copy of skin test or in vitro allergy tests if patient was tested in office.
2. Extract formula with mixes of antigens used in the formula and list components and portions in each mix.
3. Dilution, dose and date of last immunotherapy injection(s). **(and/or)**
4. Vial of Extract(s)/Serum Yes No. Mailed on Mondays ONLY. (please forward copy to Extract Dept)
5. Other (please specify) _____

***Reason for release of information**: *(Required)*

- ☐ Application for Insurance Claim
- ☐ Doctors Release (***Transferring to another Doctor***)
- ☐ Workers Compensation
- ☐ Other_____

*(Article 4495b, Section 5.08 (j) Texas Revised Civil Statues requires that an authorization for release of medical records include "the Reason or purpose stated for the release.")

This authorization is effective for 90 days, unless revoked or terminated by the patient or the patient's authorized representative.

I understand that I have the right to revoke this authorization, by mailing a completed Revocation of Authorization for Use and Disclosure of Protected Health Information form to the attention of Pam Meester, Privacy Officer at the address shown above. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits on whether or I provide authorization for the requested use or disclosure.

____ **(Patient Initial)The patient or legal guardians will be responsible for all reasonable and necessary charges to process this request. Records will not be released until payment has been received. Minimum fee $25, up to 20 pages; plus postage.**

Print Name _____ Date_____

Signature_____ _____
Patient or Authorized Representative **Relationship to Patient**

FAXED:___ MAILED:___
Date:_____
Initials:_____