NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Locations throughout Dallas – Specializing in personalized care since 1927
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PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS TO OTHER MEDICAL PRACTITONER

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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