Medical Records Release Form

By signing this form, I authorize you 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.

Patient Name:	**Date of Birth:**

RELEASE RECORDS

☐ To ☐ From	☐ From ☐ To
Lone Star Allergy & Asthma Center, PA **C/o Sven Wust, M.D.** **3304 Colorado Blvd., Suite 201** **Denton, TX 76210** **Fax: (940) 565-0700 Phone: (940) 565-5900** **DentonAllergy.com**	**Name of Entity** **Address** **City** **State** **Zip Code** **Phone** **Fax**

METHOD OF RELEASE

☐ Fax Records ☐ Mail Records ☐ Call when records are ready for pick-up

EFFECTIVE PERIOD

☐ 1 year ☐ All past, present and future periods ☐ From _________ To _________

EXTENT OF AUTHORIZATION

☐ Complete Health Records	☐ Skin Prick Test Results	☐ Blood Allergy Test Results
☐ All Laboratory Reports	☐ Sinus CT Results	☐ Pulmonary Function Testing
☐ Allergy Extract Prescription	☐ Immunotherapy Records	☐ Billing Records

☐ Other Health Records: ____

EXCEPTIONS, IF ANY

☐ HIV Results ☐ Mental Health Records ☐ Other Exceptions:

I understand that this authorization is valid for 6 months unless I notify Lone Star Allergy & Asthma Center otherwise. I may revoke this authorization in writing at any time except to the extent that any person or entity has already relied on this authorization. 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 to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient. I understand my treatment will not be conditioned by my completion of this form. I understand that this information will be provided within 15 business days after the date of receipt of the request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners and Federal Rule 164.524.

____ ____________________

SIGNATURE OF PATIENT (or if legal representative-state authority to act) Date

LSAAC STAFF ONLY	Date Released:	Copy Fee:
	Released By:	Mail Fee:
	Notes:	Account Balance:
	$25 for the first 20 pages then 50¢ per page thereafter + shipping cost	Grand Total:
	$15 for Executing an Affidavit	If non-emergent, office may retain info until payment is received