

# 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.

<b>Patient Name:</b>		<b>Date of Birth:</b>		
<b>RELEASE RECORDS</b>				
<input type="checkbox"/> <b>To</b> <input type="checkbox"/> <b>From</b>		<input type="checkbox"/> <b>From</b> <input type="checkbox"/> <b>To</b>		
<b>Mid-Cities Allergy &amp; Asthma Center</b> <input type="checkbox"/> <b>Attn: Purnima Venkatesh, M.D.</b> <input type="checkbox"/> <b>Attn: Sven Wust, M.D.</b> <input type="checkbox"/> <b>Attn: _____</b> <b>2305 Central Park Blvd.</b> <b>Bedford, TX 76022</b>  <b>Fax: (817) 868-1962      Phone: (817) 571-6622</b> <b>MidCitiesAllergy.com</b>		Name of Entity		
		Address		
		City	State	Zip Code
		Phone	Fax	
<b>METHOD OF RELEASE</b>				
<input type="checkbox"/> <b>Fax Records</b> <input type="checkbox"/> <b>Mail Records</b> <input type="checkbox"/> <b>Pick-Up in Person</b> <input type="checkbox"/> <b>Other:</b>				
<b>EFFECTIVE PERIOD</b>				
<input type="checkbox"/> <b>1 year</b> <input type="checkbox"/> <b>All past, present and future periods</b> <input type="checkbox"/> <b>From _____ To _____</b>				
<b>EXTENT OF AUTHORIZATION</b>				
<input type="checkbox"/> Complete Health Records		<input type="checkbox"/> Skin Prick Test Results		
<input type="checkbox"/> All Laboratory Reports		<input type="checkbox"/> Sinus CT Results/X-rays		
<input type="checkbox"/> X-Rays: Sinus / Chest		<input type="checkbox"/> Allergy Extract Prescription		
<input type="checkbox"/> Other Records: _____		<input type="checkbox"/> Blood Allergy Test Results		
		<input type="checkbox"/> Pulmonary Function Testing		
		<input type="checkbox"/> Immunotherapy Records		
<b>EXCEPTIONS, IF ANY</b>				
<input type="checkbox"/> <b>HIV Results</b> <input type="checkbox"/> <b>Mental Health Records</b> <input type="checkbox"/> <b>Other Exceptions:</b>				

I understand that this authorization is valid for 6 months unless I notify Mid-Cities 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 will 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

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