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REQUEST FOR MEDICAL RECORDS

Practice/Provider_________________________________ Date:_______________

Address:_______________________________City____________State______Zip Code______

Phone #_________________________________ Fax #________________________________

Please mail records to:

Austin Family Allergy & Asthma
10801-2 North Mopac Expwy. Suite 150
Austin, TX. 78759

Or Fax records to: 512-338-4450

Please provide the medical information requested below pertaining to my medical care in your office from _______________ to date. Thank you for your prompt response to my request.

____
Parent or Legal Guardian Signature

Please Print
Patient Name:____

Parent's Name, if applicable:________________________________

Patient's previous/Maiden name:____________________________

Patient's Birthdate:____________________

The following records are requested:

____Initial History and Physical
____Hospital Discharge Summary
____X-Ray Reports________________
____Lab Reports
____Brief summary of office care
____All Skin Test/RAST Results
____Progress Notes
____Consultation Reports
____Pulmonary Function Studies
____Extract Formula

Please include specific antigens, concentration, volume, and supplier.
Your cooperation is greatly appreciated. Thank you for helping us to provide appropriate continuing care to this patient.