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Medical Records Release

Patient Name:_____ Date of Birth:_____

By signing this form, I authorize Austin Family Allergy and Asthma to release my Protected Health Information to: (Check one) Physician___ Individual___Facility___Entity___ listed below.

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.
Initial:_____ Date:_____

The information you may release subject to this signed release form is as follows:
_____Complete Records
_____Records from _____ to _____
_____Pulmonary Function Studies
_____Labs / Skin Tests
_____Other:_____

Release my protected health information to the following:

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Telephone:_____ Fax:_____

The purpose / reason for this release of information is as follows:

_____

_____

_____

_____ _____ _____
Signature of Patient or Authorized Person Relationship Date