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## REQUEST FOR MEDICAL RECORDS

To: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please mail records to:

Austin Family Allergy & Asthma  
10801 N.Mopac Expwy  
Bldg 2, 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*

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Please Print

Patient Name: \_\_\_\_\_

Parent's Name, if applicable: \_\_\_\_\_

Patient's previous/Maiden name: \_\_\_\_\_

Patient's Birthdate: \_\_\_\_\_

The following records are requested:

- |   |   |
|---|---|
| <input type="checkbox"/> Initial History and Physical | <input type="checkbox"/> Progress Notes             |
| <input type="checkbox"/> Hospital Discharge Summary   | <input type="checkbox"/> Consultation Reports       |
| <input type="checkbox"/> X-Ray Reports _____          | <input type="checkbox"/> Pulmonary Function Studies |
| <input type="checkbox"/> Lab Reports                  | <input type="checkbox"/> Extract Formula            |
| <input type="checkbox"/> Brief summary of office care |   |
| <input type="checkbox"/> All Skin Test/RAST Results   |   |

*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.