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# Medical Records Release

Patient Name: _____ Date of Birth:_____

By signing this form, I authorize Austin Family Allergy & 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.

Yes_____ No_____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