TEXAS REGIONAL ASTHMA AND ALLERGY CENTER, L.L.P.

Board Certified specialists in allergy, asthma, immunology, and respiratory disorders
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WEBSITE: www.traac.org

Medical Record Release Form

Patient Name: _____ DOB: _____ SSN: _____

This request expires on_____. If left blank, expires 1 year from signing or until revoked in writing.

*I authorize you (TRAAC) 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:

Doctors Name:_____
City: _____ State: _____ Zip Code: _____
Fax: _____ Phone: _____
Email:_____

Dates of information to be disclosed: From _____ to _____. If left blank only information from the past two years will be disclosed.

Information to be disclosed:

- All medical records related to: *(Specify condition, treatment, etc.)*_____
- All diagnostic testing related to: *(Specify condition, treatment, etc.)*_____
- All billing records related to: *(Specify condition, treatment, etc.)*_____

I do not want the following information disclosed (as defined by applicable state and federal laws):

- Alcohol/Drug Abuse
- HIV Test Results
- Mental Health/Developmental Disabilities

I understand that there may be a fee associated with the release of my medical records and agree to payment.

_____	_____	_____
Patient/Guardian printed name	Patient/Guardian signature	Date