

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

Board Certified specialists in allergy, asthma, immunology, and respiratory disorders

RENE ALBERT LEON, M.D. ALI SHAKOURI, M.D. ERNESTO RUIZ-HUIDOBRO, M.D.
ALLISON LEGARE, PA-C HAYLEY REBECCA HAUSER, PA-C JESSE ASTORGA, PA-C
900 East Southlake Blvd. Suite 300 Southlake Texas 76092 (817) 421-0770 (817) 421-4759 (Fax)
3349 Golden Triangle Blvd Fort Worth, TX 76177 (817) 421-0770 (817) 562-5008 (Fax)
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