

# 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](http://www.traac.org)

## Medical Record Request 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 **request** confidential health information about me from the person(s) or entity listed below:

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

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

- Transfer of another provider
- Personal File
- Payment of Bill
- Insurance/Work/Second opinion
- Attorney
- Other: \_\_\_\_\_

Please forward the requested information to:

**Texas Regional Asthma & Allergy Center**  
900 E. Southlake Blvd. Suite 300  
Southlake, TX 76092  
817-421-0770 (Phone)      817-421-4759 (Fax)

\_\_\_\_\_  
Patient/Guardian printed name

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date