

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 for Personal Use

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:

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 understand there is a fee associated with the release of my medical records and agree to payment.

Patient/Guardian printed name

Patient/Guardian signature

Date