

Allergy & Immunology Medical Center
248 Addie Roy Road, Suite B201
Austin, Texas 78746
(512)329-5800 Phone (512)329-5807 Fax

Medical Record #
Name
Date of Birth
SSN

Authorization to Obtain Patient Information

Obtain from: (Releasing Facility) _____ Name _____ Address _____ City State Zip _____ Phone Fax	Release to: (Receiving Facility) <u>Allergy & Immunology Medical Center</u> <u>248 Addie Roy Road, Suite B201</u> <u>Austin, Texas 78746</u> <u>(512) 329-5800</u> <u>(512) 329-5807</u> Phone Fax
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I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by federal privacy laws. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Date of service range (month/year): From: _____ To: _____
INFORMATION TO BE REVIEWED: IN ELECTRONIC MEDICAL RECORD ONLY _____
DURING PATIENT ADMISSION/VISIT _____ **IN HEALTH INFORMATION DEPARTMENT** _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

- | | | |
|--|--|---|
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Mental Health Treatment | <input type="checkbox"/> Genetic Information |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> HIV/AIDS information |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> X-Ray Films-maintained by radiology department |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clinic/progress notes | <input type="checkbox"/> Immunization Records | _____ |

INFORMATION IS TO BE USED FOR:

- Continuity of Medical Care Damage/Claim Information Personal Use
Other: _____

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is no later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

Signature of Patient or Authorized Representative

Date of Signature

Printed Name

Relation to Patient (if applicable)

PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS

I hereby acknowledge that I the patient/authorized representative have reviewed _____ and/or received _____ photocopies of the medical records for the above named patient.

Date Signature Date Witness Signature

