| | |
|---|---|
| Allergy & Immunology Medical Center | Medical Record # |
| 102 Westlake Drive Suite 104 | Name |
| Austin, Texas 78746 | Date of Birth |
| (512)329-5800 Phone (512)329-5807 Fax | SSN |

**Authorization to Obtain Patient Information**

| Obtain from: (Releasing Facility) | Release to: (Receiving Facility) |
|---|---|
| _____ | Allergy & Immunology Medical Center |
| Name | |
| _____ | 102 Westlake Drive, Suite 104 |
| Address | |
| _____ | Austin, Texas 78746 |
| City State Zip | |
| _____ | (512) 329-5800 (512) 329-5807 |
| Phone Fax | Phone Fax |

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)**

| | | |
|---|---|---|
| ____Emergency Room Report | ____Mental Health Treatment | ____Genetic Information |
| ____Discharge Summary | ____Drug/Alcohol Treatment | ____HIV/AIDS information |
| ____Operative Report | ____Radiology Reports | ____X-Ray Films-maintained by radiology department |
| ____History and Physical | ____Laboratory Results | ____Other:_____ |
| ____Clinic/progress notes | ____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 |

ALLERGY & IMMUNOLOGY
MEDICAL CENTER