9101 North Central Expressway, Suite 430
Dallas, TX 75231
Phone: 214-363-8889
Fax: 214-363-9416

MEDICAL RECORDS REQUEST AUTHORIZATION

I hereby authorize the release of my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

From:_____

Address:_____

City:_____ State: _____Zip: _____

To: Park Lane Allergy and Asthma Center
9101 North Central Expressway, Suite 430
Dallas, TX 75231
Phone: 214-363-8889
Fax: 214-363-9416

_____ _____

(Patient's Name) **(Patient's Date of Birth)**

Signed by:_____ _____
(Signature of Patient or Legal Guardian) (Relationship to Patient)

_____ _____
(Print Name of Patient or Legal Guardian) (Today's Date)

This authorization will expire one year from date of authorization or: _____.
{Expiration Date or Defined Event}