



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

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize **Park Lane Allergy and Asthma Center** to release 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.

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Please indicate the purpose or reason for this request:

_____ Consulting a new physician in a different specialty.

_____ Moving out of the area.

_____ Transferring medical care to another allergist.

_____ Copy for my personal record.

_____ Other: _____

(Patient's Name)

(Patient's Date of Birth)

I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that **Park Lane Allergy and Asthma Center** has taken action in reliance on it. A revocation is effective upon receipt of a written request to revoke authorization.

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}