



PLANO
6101 Windcom Court
Suite 400
Plano, TX 75093
Ph: (972) 398-3500
Fax: (972) 398-3512

DENTON
3105 Colorado Blvd.
Suite 101
Denton, TX 76210
Ph: (940) 387-1700
Fax: (940) 387-1722

DENISON
5012 South US HWY 75
Suite 150
Denison, TX 75020
Ph: (903) 463-8400
Fax: (903) 463-8500

Patient Name: _____
Patient Address: _____
Date of Birth: _____ Sex: _____
Daytime Phone: _____ (Hm/Wk/Mb)
Allergist: _____

➤ I hereby authorize Southwest Allergy and Asthma Center to disclose my protected health information. I understand that a processing fee may apply and identification will be required to protect patient privacy and confidentiality.

➤ I understand that the information is to be released for the following purpose (please select one):

- Continuation of Care
 Consultation
 Transfer of Care
 Other: _____

➤ Information to be released (please select all that apply):

- All Records
 Radiology Reports
 Allergy Shot Records
 Progress Notes
 Vaccination Records
 Allergy Test Results
 Labs
 Allergy Shot Recipe
 Other (please specify): _____

➤ Time period or date of information to be released: From: _____ To: _____
(Month/Year) (Month/Year)

➤ I understand that the requested records will be:

- Mailed to OR
 Picked up by OR
 Faxed to

Name: _____

Attn: _____

Address: _____

City, State, Zip

Phone: _____ Fax: _____

- ◆ I understand that the records used and disclosed pursuant to this authorization may include information relating to: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health or psychiatric care; and/or other sensitive information.
- ◆ I understand that I may revoke this authorization in writing at any time, except to the extent that Southwest Allergy & Asthma Center has relied on this authorization. Unless otherwise revoked, I understand that the date or event upon which this authorization expires is **180 days** from the date of signature. A photostatic copy of this authorization is considered as valid as the original.
- ◆ I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and, therefore, may be subject to re-disclosure by the recipient.
- ◆ I understand that according to Chapter 159 of the Texas Occupational Code Section 159.005 (e) and HIPAA, a re-disclosure could be made from records received from another health care provider involved in my care or treatment.
- ◆ Southwest Allergy and Asthma Center will not condition treatment, payment, enrollment or eligibility for benefits based upon the completion of this form.
- ◆ Please allow 2 business days for completion of this request.

Patient's Printed Name

Patient's Signature

Date

*Legal Representative's Printed Name

Legal Representative Signature

Date

If representative, specify relationship to patient

**Note: Proof of legal authority may be required for legal representatives*