

ALLERGY & ASTHMA CONSULTANTS, L.L.P.

800 West 34th St. · Suite 201 · Austin, Texas 78705-1102

Office Phone (512) 454-5821 Fax (512) 459-9137

www.austinallergy.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby authorize release of information from the medical record of:

Patient Label

Please fax this form as a cover sheet with the requested records to the attention of the Medical Records Department. Thank you.

FROM: (Print Name/Address of Sending Doctor)

TO: Please send/mail to :(Check Doctor)

- T.S. Painter, Jr., MD, PA
- Edward J. Peters, MD, PA
- Maria G. Gutierrez, MD, PA
- Paul G. Vigo, MD, PA
- John P. Dice, MD, PA

**@ 800 West 34th St. Ste 201
Austin, Texas 78705-1102**

Please send copies of medical records for the above patient from the following period:

From _____ To _____

Records will include:

1. Copy of skin tests or in vitro allergy tests if patient was tested in office.
2. Extract formula with mixes of antigens used in the formula and list components and portions in each mix.
3. Dilution, dose and date of last immunotherapy injection. **(and/or)**
4. Other (please specify) _____

***Reason for release of information: (Required)**

- Application for Insurance Claim
- Doctors Release
- Workers Compensation
- Other _____

*(Article 4495b, Section 5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the Reason or purpose stated for the release.")

This authorization is effective through _____, unless revoked or terminated by the patient or the patient's authorized representative.

I understand that I have the right to revoke this authorization, by mailing a completed **Revocation of Authorization for Use and Disclosure of Protected Health Information** form to the attention of **Tammy J. Clinard, Privacy Officer** at the address shown above. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. In addition, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature _____
Patient or Authorized Representative

Date _____

Relationship to Patient (Reason Patient is unable to sign)

Witness _____