

**MEDICAL RECORDS RELEASE**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I authorize Park Cities Allergy and Asthma to release my/my child’s confidential health information by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Release my protected health information to the following person(s) / entity:

Name:

Street:

City: State: Zip:

Phone:

Fax:

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Patient name: Date:

Patient Signature:

 (Parent, guardian, or legal representative)