



Patient Name: _____ Patient Address: _____ _____ <div style="text-align: center;">City, State, Zip</div> Date of Birth: _____ Sex: _____ Daytime Phone: _____ (Hm/Wk/Mb) Allergist: _____
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➤ I hereby authorize Name: \_\_\_\_\_  
 Attn: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  

City, State, Zip

 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

➤ 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 sent to:

Name: Southwest Allergy & Asthma Center  
 Address: 6100 Windcom Court, Suite 101  
 Plano, TX 75093  
 Phone: (972) 398-3500 Fax: (972) 398-3512

- ◆ 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.

\_\_\_\_\_  
 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*