DALLAS ALLERGY & ASTHMA CENTER

GARY N. GROSS, MD
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

1. Patient Name:_____

   Date of Birth:_____ Phone#:_____

   Persons/organization(s) **providing** the records:
   (Complete address/phone #/fax #)

   _____

   _____

   _____

   _____

   Persons/organization(s) **receiving** the records:
   (Complete address/phone #/fax #)

   _____

   _____

   _____

   _____

   Covering all the periods of care from: _____to_____

2. Information to be released:

   _____ Copy of complete medical records
   _____ Excluding information related to HIV testing and/or results
   _____ History and Physical
   _____ Skin Testing results/RAST results
   _____ Pulmonary Function Studies
   _____ X-Ray reports
   _____ Exact composition of current allergenic extract
   _____ Other_____

3. Purpose of Disclosure: _____to send to insurance company
   _____ to send to new family/general physician
   _____ to transfer care to a new allergist

4. I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

5. Specification of the date, event of condition upon which this consent expires:

   _____

6. The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

PLEASE NOTE: A $25 FEE WILL BE ASSESSED FOR COPIES REQUESTED FOR PERSONAL MATTERS
(I.e. personal copies, life insurance policy and attorney requests)

Signed: _____ Date: _____
Patient or Representative

_____
Relationship to Patient

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