



MEDICAL RECORDS DISCLOSURE FORM

Patient: _____
Printed Name (First, Last, MI) Date of Birth

Release To: _____
Name of Recipient (Person, Clinic, Hospital, Insurance Company, Attorney, etc)

Address

City, State and Zip Code Date Information Needed

Please specify what records you would like to inspect or copy:

- All medical records All records between the dates of _____ and _____
- Records pertaining to: _____

Please specify method of release:

- Pick-up in Person Certified Mail Other: _____

A fee may be charged in accordance with the Texas State Medical Board of Medical Examiners and Federal Rule 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. I understand that a photocopy or facsimile of this authorization will be treated in the same manner as an original. Further, I realize that the disclosing entity is required to hereby inform me that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal **HIPPA Privacy Rule**, and therefore the disclosing entity and all their staff members are released from any and all liability resulting from re-disclosure. I hereby authorize Lone Star Allergy & Asthma Center to disclose the medical records stipulated above to the recipient named above. This authorization, solely as it relates to disclosure of health care information, will expire 1 year from the date of signature below unless specified otherwise.

Patient/Parent/Legal Guardian or Representative Signature Date Authority to act on behalf of patient (attach document)

Request completed by:	Address changes made: <input type="checkbox"/>	Copy Fee: \$
Date mailed/picked-up:	Number of pages:	Mailing Fee: \$
\$25 for the first 20 pages then 15¢ per page thereafter + Actual shipping cost		Account Balance:\$
\$15 for Executing an Affidavit + Additional Fees for Billing Records		Grand Total: \$