



Request for Medical Records

Date: _____

To: _____

Patient: _____

DOB: _____

I hereby authorize the release of all my medical records and test results, including HIV test results, in your possession regarding my illness and/or treatment.

Please release:

- All available records
- All available records from the past 12 months
- All available records from _____ through _____
- X-Ray Reports
 - All X-Rays
 - Sinus CT scan
 - Other: _____

If possible, please fax ASAP as the patient is currently in our office.
Thank you!

- Chest X-Ray
- Chest CT scan
- Lab tests
 - All available
 - Tests performed from _____ through _____
 - Specific: _____

(210) 692-7833 Babcock Office
 (210) 932-2788 Barlite Office

- Allergy tests
 - Previous allergy skin tests
 - Previous allergy blood tests (eg., RAST, Immuno CAP)
- Immunotherapy (Allergy Shot) Records
 - Extract prescription/ingredients/recipe card
 - Allergy shot record/log from _____ through _____

_____ I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified.

_____ I understand that in compliance with Texas State Board of Medical Examiners (TSBME), I will pay a fee of \$25.00 for the first 20 pages and \$0.50 for each additional page. The fee will be waived if records are requested from facilities for ongoing care, follow up treatment or for insurance payment.

_____ I understand that records should be released within two weeks of my request.

I release you, your physicians and employees from liability for following this authorization and request.

Thank you so much for your assistance.

Signature

Legal Guardian Signature

Witness Signature

Date (Valid for 90 days from this date)

Main Office:
Medical Center
2414 Babcock Rd. Ste 109
San Antonio, TX 78229

Southside:
SW Medical Bldg.
7500 Barlite Blvd. Ste 106
San Antonio, TX 78224

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