# Medical Records Request

Patient Name: _____ DOB: _____

I am requesting records from:

Physician's Office/Facility Name: _____

Phone Number: _____

Fax Number: _____

By signing this form, I authorize _____
(Physician's Office/Facility Name)
to release confidential health information about me/my child by releasing a copy of my medical records to Highland Park Allergy and Asthma Specialists.

**Please send visit notes, labs, imaging results, allergy testing, IT log and recipe.**

Release my protected health information to:

Highland Park Allergy and Asthma Specialists
8201 Preston Rd. Ste 460 Dallas, TX 75225
Phone: 469-310-3681 Fax: 214-238-8084

Printed Name: _____ Date: _____

Signature: _____