Highland Park
ALLERGY & ASTHMA
SPECIALISTS

# MEDICAL RECORDS RELEASE

Patient Name: _____ D.O.B: _____

By signing this form, I authorize Highland Park Allergy and Asthma Specialists to release my/my child's confidential health information by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Release my protected health information to the following person(s) / entity:

Name: _____

Street: _____

City: _____ State: _____ Zip:_____

Phone: _____

Fax: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Patient name: _____ Date: _____

Patient Signature: _____
(Parent, guardian, or legal representative)

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