

Chisholm Trail Allergy and Asthma  
7200 Dutch Branch Rd. #200  
Fort Worth, TX 76132  
817-346-7676 ph  
817-346-7779 fx

General Medical Records Release and  
Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

I authorize the custodian of records: \_\_\_\_\_ to disclose/release the following  
(doctor's office name/doctor's name)  
information\* (check all if applicable)

- |   |  |
|---|--|
| <input type="checkbox"/> All Allergy Records        | <input type="checkbox"/> Abstract/Summery                    |
| <input type="checkbox"/> Allergy Laboratory Records | <input type="checkbox"/> Pharmacy/prescription records       |
| <input type="checkbox"/> X-ray/radiology records    | <input type="checkbox"/> Other (describe specifically) _____ |
| <input type="checkbox"/> Billing records            | _____  |

\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): \_\_\_\_\_  
Please send the records listed above to:

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Chisholm Trail Allergy and Asthma | <input type="checkbox"/> Name: _____ |
| 7200 Dutch Branch Rd. #200                                 | Address: _____                       |
| Fort Worth, TX 76132                                       | _____                                |
| 817-346-7676ph 817-346-7779fx                              | Ph/Fx: _____                         |

The information may be used/disclosed for each of the following purposes:

- |  |  |
|--|--|
| <input type="checkbox"/> At my request (only the patient can check this box) | <input type="checkbox"/> For employment purposes |
| <input type="checkbox"/> For my health care                                  | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> For payment/insurance                               |  |

This authorization shall expire no later than: \_\_\_/\_\_\_/\_\_\_, and may not be valid for greater than one year from the date of signature for medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

\_\_\_\_\_  
Signature of patient (or patient's representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient/representative

\_\_\_\_\_  
Representative's authority to sign for  
Patient, (i.e. parent, guardian, POA for healthcare,  
Executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to 7200 Dutch Branch Rd. #200, Fort Worth, TX 76132

**A copy of this signed authorization must be giving to the individual.**