ALLERGY & RHEUMATOLOGY
SPECIALISTS OF HOUSTON

12000 Richmond Ave., Ste 175
Houston, TX 77082
Phone 713.790.0900
Fax 713.790.0901
www. arshclinic.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT'S NAME (Print or Type): _____

Date of Birth: _____ Social Security # (last 4 digits): _____

RECORDS REQUESTED **FROM** (Person/Facility):

Name: Allergy & Rheumatology Specialists of Houston

Address: 12000 Richmond Ave., Suite 175

City: Houston State: TX Zip: 77082

Phone: 713-790-0900 Fax: 713-790-0901

INFORMATION REQUESTED (Please check):

_____ All healthcare information
_____ Physician notes
_____ Lab Reports
_____ X-ray, CAT scan, MRI reports, etc.
_____ EKG or other cardiac tests
_____ Other _____

SENSITIVE INFORMATION, INCLUDING DIAGNOSIS, TREATMENT AND/OR STATUS OF ACQUIRED IMMUNE DEFICIENCY (i.e. AIDS OR HIV), SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC/ MENTAL HEALTH CONDITION(S), DRUG AND/OR ALCOHOL ABUSE, WILL NOT BE RELEASED UNLESS YOU SIGN HERE:

X _____
Signature of Patient or Legal Guardian

PURPOSE OF DISCLOSURE:

_____ Attorney/Legal
_____ Commercial Insurance
_____ Worker's Compensation
__X__ Continue and/or Transfer Patient Care
_____ Personal Use
_____ Other _____

RECORDS RELEASED **TO** (Person/Facility):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

This consent will expire ninety days after date of signature. Allergy & Rheumatology Specialists of Houston, its employees and partners, and attending physicians are released from legal responsibility or liability for release of above information to extent indicated and authorized herein.

SIGNATURE: _____ DATE: _____
(Patient or Legal Guardian)

WITNESS: _____ DATE: _____