



ALLERGY & RHEUMATOLOGY SPECIALISTS OF HOUSTON

12000 RICHMOND AVE, STE 175
HOUSTON, TX 77082
PHONE 713.790.0900
FAX 713.790.0901
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: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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
 Continue and/or Transfer Patient Care
 Personal Use
 Other _____

RECORDS RELEASED TO (Person/Facility):

Name: Allergy & Rheumatology Specialists of Houston

Address: 12000 Richmond Avenue, Suite 175

City: Houston State: TX Zip: 77082

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

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: _____