**Allergy, Asthma & Immunology Center (AAIC),** PLLC.

**SRIVIDYA SRIDHARA, MD**

623 W FM 544, Suite #104 8080 Independence Parkway Suite #150

Murphy, TX 75094 Plano, TX 75025

Phone: 972-521-3366 Phone: 972-521-3366

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**Top of Form**

**Bottom of Form**

**AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS TO AAIC**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request to transfer care from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I permit authorization for transfer of my medical records.

To: Allergy, Asthma & Immunology Center, PLLC

623 W FM 544, Suite #104

Murphy, TX 75094

Phone: 972-521-3366 Fax: 972-422-5656

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please transfer the requested information:

- All Patient Records from your facility

- Allergy test results (lab, skin testing), Lab results, Spirometry

- Medical records from prior physicians that are currently in my chart

- ALLERGEN EXTRACTS FOR ALLERGY SHOTS AND ALLERGEN RECIPES

- Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your initials are required to release the following:

\_\_\_\_Mental Health Records (excluding psychotherapy notes)

\_\_\_\_Genetic Information (including Genetic Test Results)

\_\_\_\_Drug, alcohol, or Substance Abuse Records

\_\_\_\_HIV/AIDS Test results/Treatment

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of legally authorized representative if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If representative, specify relationship of individual: Parent of Minor or Guardian or Other\_\_\_\_\_\_\_\_\_\_\_\_

Effective Time Period:

This authorization is valid until the permission is withdrawn or 1 year from date of signature.

For office use only:

Allergy, Asthma & Immunology Center

Date received: \_\_/\_\_\_/\_\_\_\_\_\_ Date processed: \_\_/\_\_\_/\_\_\_\_\_\_ Office personnel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_