NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Locations throughout Dallas – Specializing in personalized care since 1927
Main: (214) 369-1901 ~ Fax: (214) 369-1905
Web: www.texasallergy.com
E-mail: general@texasallergyonline.com
Portal: portal.texasallergyonline.com

Patient Authorization to Release Medical Records to NTAAA

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

I authorize _____ to release my medical information and/or individually identifiable health information to North Texas Allergy & Asthma Associates (NTAAA) as may be required or permitted under federal or state law. I further authorize physician to release such information to physicians, hospital, or healthcare providers needing such information to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I also understand that this authorization may be revoked by me by a written and dated notice, except to the extent that disclosure of information has been made prior or receipt of such revocation.

I authorize the use of a copy of this release and consent in place of the original.

Patient Signature: _____

If a minor, authorized representative of Patient:

Relationship: _____

Name: _____

Signature: _____

Information Requested:

_____

_____

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