Aspire ALLERGY & SINUS

GENERAL INBOUND REQUEST

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient Full Name: _____ **Patient DOB:** _____
Patient Address: _____
Phone: _____ **Email Address:** _____

Please fill in the information below completely any missing information will result in the rejection of your request

I hereby authorize Aspire Allergy & Sinus to request medical record information for continuation of care. from:

Office Name/Physician Full Name: _____
Office Address: _____
Office Phone:_____**Fax:**_____

Please provide fax number to process your request

Information to be released for Patients Continuing Care Please only mark what you are requesting checking other options can result in a delay of receiving your records.

___Clinical Notes____Testing Results____Labs____CT (CD)Scans___CT Report____Complete Chart

Notes: _____

_____

Patient Signature:_____**Date:** _____
(Or responsible party)

If other than patient, please disclose relationship: _____

Email Request to: medical.records@txna.onmicrosoft.com

Or Fax to 877-891-0383 If you have any questions, please call 210-960-3837

******************************Please allow 15 days to Process Request ********************************

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specific information to be released may include, but is not limited to: diagnosis, and/or treatment of drugs and alcohol abuse, mental illness, or communicable disease, Including Human Immunodeficiency Virus (HIV)and Acquired Immune Deficiency Syndrome (Aids). 45 CFR § 164.502(a)(2)(iii)