Allergy & Asthma
TEXAS HEALTH
Together we can!

ARACELI ELIZALDE, MD
Board Certified Adult & Pediatric Allergist and Immunologist

Authorization for Release of Health Information

I, _____do hereby authorize _____ to disclose protected health information pertaining to the following person:

Patient Identification:

Printed Name_____

Date of Birth: _____ Social Security Number: _____

Health information to be released:

From (date) _____to (date) _____

Please check type of information to be released:

___ Complete Health Record	___ History & Physical Exam	___Diagnosis/Treatment Codes
___ Billing Records	___ Medication Record	___ Photographs, Videotapes
___ Consultation Reports	___ Progress Notes	___ EKG
___ Operative Report(s)	___ Laboratory Test Results	___ Radiology Films/ Images
___ Radiology Reports	___ Cardiology Comp. Disk/tape	___ Pathology
___ Discharge Summary	___ Prescription Records	___ Treatment Records

___ Abstract of Health Record (All Transcribed Physician Reports & Test Results)
___Other,(specify): Authorization is given for Allergy & Asthma Texas Health to discuss my care and treatment with _____

Purpose of Request:

_____ Claim investigation
_____ At the request of the individual claimant
_____ Other (specify): _____

I understand and authorize the identified health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or service to me or on my behalf ("My Providers") to disclose, by written and/or verbal release of information, my entire medical record and any other protected health information concerning me to Allergy & Asthma Texas Health, its agents, employees, and representatives for the purposes of claims investigation prepared in anticipation of civil litigation.

I authorize _____to release the protected health information specified above.

Signature: _____ Date: _____

Printed Name: _____

If Signed by Other Than Patient; Indicate Relationship: _____