McKinney
Allergy and Asthma Center

2251 West Eldorado Parkway
Suite 150
McKinney, TX 75070

(P) 972-548-2797
(F) 972-548-2788
www.mckinney-allergy.com

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS

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: McKinney Allergy and Asthma Center
2251 West Eldorado Parkway, Suite 150
McKinney, TX 75070
Phone: 972-548-2797 Fax: 972-548-2788
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 ☐Guardian ☐Other_____*

Effective Time Period:
This authorization is valid unti the until the permission is withdrawn or 1 year from date of signature.

For office use only:
Date received: __/___/_____ Date processed: __/___/_____ Office personnel: _____