Aspire ALLERGY & SINUS

INBOUND REQUEST

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient Full Name:_____Patient DOB: _____
Patient Address: _____
Phone:_____Email Address: _____

Requesting physician: ***(Check requesting physician)***

_____Christopher Thompson, MD
_____Robert Fulmer, MD
_____Haley Overstreet, MD
_____Stacy Silvers, MD
_____Alvin Aubry, MD
_____Richard Wachs, MD
_____ Santiago Martinez, MD

_____ Dr Schmitt, MD
_____ Kirk Waibel, MD
_____Savannah Sommerhalder, MD
_____ William Storms, MD
____ Dr Andrews, MD
____ Suresh Raja, MD
_____ Rafiquddin Rahimi, MD

Other Providers: _____

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 from:

Office Name/Physician Full Name: _____
Office Address: _____
Office Phone:_____Fax: _____

Information to be released for Patients Continuing Care Please only mark what you are requesting

___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 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 not 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)