ADVANCED
ALLERGY & ASTHMA
ASSOCIATES

Swapnil Vaidya, MD PhD
ALLERGY, ASTHMA & IMMUNOLOGY

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
Last First MI

SSN: _____ Phone: _____

I authorize the release of medical records as follows:

From / To (Circle one)	From / To (Circle one)
Advanced Allergy & Asthma Associates	_____
5320 N. Tarrant Pkwy, Ste 220	_____
Fort Worth, TX 76244	_____
Phone: (817) 428-7000	Phone: _____
Fax: (817) 428-7006	Fax: _____

Requested Information: _____

_____
(Office visit notes, Allergy Testing, Entire Chart etc.)

Dates of Service: _____

This authorization expires 30 days from the date of the signature below. I understand that I may revoke this authorization at any time with a written, signed and dated notice; however, disclosures made prior to the revocation will not be affected. A copy of this authorization may be used in place of the original with the same effectiveness. I understand there may be fees associated with making copies and mailing these records.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Print Name Relationship to patient