ADVANCED ALLERGY & ASTHMA ASSOCIATES

Swapnil Vaidya, MD PhD
Kellie Vaidya, MPH, PA-C
Dalia Galicia, MD
ALLERGY, ASTHMA & IMMUNOLOGY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____ PHONE#: _____

I authorize the release of medical records as follows:

FROM / TO (Circle One)
Advanced Allergy & Asthma Associates
9433 N. Beach St. Suite 111
Fort Worth, TX 76244
Phone: 817-428-7000
Fax: 817-428-7006
OR
540 E. Southlake Blvd. Suite 140
Southlake, TX 75092
Phone: 817-410-2111
Fax: 817-410-2113

FROM / TO (Circle One)
_____
_____
_____
Phone: _____
Fax: _____

Requested Information: _____
_____
(e.g. 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