JEFFREY STEWART HALLETT, M.D.
Diplomate, American Board of Allergy & Immunology

Certified Allergy and Asthma of San Antonio
Phone (210) 614-3923 Fax (210) 614-9306

AUTHORIZATION FOR MEDICAL RECORDS

PATIENT:_____ _____
(Last Name) (First Name) (MI) Date of Birth

E-MAIL ADDRESS: _____

I Wish To Have My Records Transferred To The Physician Designated Below:

Physician's Name: _____
Address: _____
_____
_____
TEL: _____
FAX: _____

Please Return This Form To One Of The Following:

E-mail: fax@certifiedallergysa.com

Fax: 210-614-9306 (ATTN: Dr. Hallett)

U.S. Mail: Certified Allergy & Asthma of San Antonio
ATTN: Dr. Hallett
8285 Fredericksburg Road
San Antonio, Texas 78229

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person.

I understand that the information released could contain reference to any positive or negative test result for AIDS or HIV infection, antibodies to AIDS/HIV, or infection with any other causative agent of AIDS.

I understand that my medical record may contain reports, test results, and notes that only a physician can appropriately interpret. I understand and have been advised that I should contact my physician regarding entries made in my medical record, to prevent any misunderstanding or misinterpretation of the information that has been written in the record.

I understand that this request will be processed and completed within fifteen (15) working days of receipt of request. I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, and that revocation of this consent must be in writing. In any event, this authorization expires automatically ninety (90) days from the date of my witnessed signature, unless otherwise specified.

X _____ _____
Signature - Patient or Guardian (If guardian, state relationship to patient) **Date**

FOR OFFICE USE ONLY: Request Date:_____ Completion Date:_____