CONSENT FOR RELEASE OF INFORMATION

I hearby authorize: Date: ____________

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to release the following information from the health records of:

____ ________________________

Patient Name Social Security Number

____ ________________________

Address Date of Birth

_______ all records _____ records covering the period of care from __________ to ________________________

Information to be released:

_______ Copy of Health Records including:

-Allergy Testing Record -History and Physical Notes

-Allergy Immunotherapy Records -Laboratory Results and Radiology Report

_______ Other: ____

Information is to be released to:

Robert D. Cook, M.D., P.A.
Central Texas Allergy and Asthma Center
4150 North Lamar Austin, TX 78756
(512) 467-0978 Fax (512) 467-8066

Purpose of Disclosure: ____

_______ Confer with other person orally about information in my medical record ____________________

Name Relationship to Patient

Reports may include information on drug/alcohol/psychological or communicable disease treatment. I waive the privilege of confidentiality of such information.

HIV/AIDS I consent to the release of any positive or negative test result for AIDS of HIV infection, antibodies to AIDS of infection with any other causative agent of AIDS with the rest of my medical records.

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, in any event, this authorization expires automatically in ninety (90) days from the date of signature or as otherwise specified.

I understand that you will provide this information within 15 days from receipt of request (per Medical Practice Act of the Texas State Board of Medical Examiners) and that a fee for preparing and furnishing this information may be charged. The fee is waived if the records are to be used for supporting an application for disability or other benefits or assistance under a) Aid to Families with Dependent Children, b) Medicaid, c) Medicare, d) Supplemental Security Income, and e) Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed:

____ ________________________

Patient or Representative Date

____

Relationship to Patient

____ ________________________

Witness Date