Allergy & Asthma Care of Houston, P.A.	14090 Southwest Freeway, Suite 306 Sugar Land, TX 77478 Office 281.645.6401 Fax 281.277.8872

REQUEST FOR MEDICAL RECORD

To:

Medical Facility:______________________________

Address: ______________________________

City, State, Zip:______________________________

Phone: ______________________________

Fax: ______________________________

I hereby authorize the release of all my medical records and test results including HIV test results, in your possession regarding my medical condition. Please send of fax record to:

Dr. Joseph R. Perez
Allergy & Asthma Care of Houston, P.A
14090 Southwest Freeway, Suite 306
Sugar Land, TX 77478
Fax: 281.277.8872

I release you from liability for following this request.

Patient Name:

Date of Birth:

Signature: ______________________________

Date: