

DallasAllergyImmunology

Medical Records Release

Patient Name _____ DOB _____

Address _____ Phone _____

Please circle:

From / To

From / To

DallasAllergyImmunology _____

7777 Forest Lane - Suite B-332 _____

Dallas, Texas 75230 _____

Phone 972-566-7788 _____ Phone _____

Location requested to pick up records at: _____ Medical City Dallas _____ Frisco

OR

Send via Email - Address _____

(The patient must be registered through our secure website)

Requested Information _____

(Labs, Office visits, Entire chart)

Date(s) of Service(s) _____

Patient/Guardian Signature _____ Date _____

(18 yrs of age or older)

Witness _____ Date _____

Processing time is 10 to 15 business days.

This Request is good for 30 days from above date entered.

Patient is responsible for cost of mailing medical records.

Credit Card Number _____ Exp Date _____

Signature _____

Name shown on card _____

7777 Forest Lane, Suite B-332, Dallas, Texas 75230 • 4500 Hillcrest Road, Suite 150, Frisco, Texas 75035
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www.dallasallergy.net