

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 Secure Messaging - 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