

# Allergy & Asthma Care of Houston

14090 Southwest Freeway, Suite 101  
Sugar Land, TX 77478  
Office 281.645.6401  
Fax 281.576.7519

## REQUEST FOR MEDICAL RECORD

To:

Medical Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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 Perez  
Allergy & Asthma Care of Houston  
14090 Southwest Freeway, Suite 101  
Sugar Land, TX 77478  
Fax: 281.645.6401

I release you from liability for following this request.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_