

# TRANSFER AUTHORIZATION FORM

[Request for Medical Records]

**Transferring  
From:**

\_\_\_\_\_  
Physician or Practice Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

.....

**Patient  
Information:**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

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

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Alternate Phone Number

I hereby authorize the physician or medical practice that I have named above to release my (or my child's) medical records to Lone Star Allergy & Asthma Center, P.A. This authorization, solely as it relates to disclosure of health care information, will expire 90 days after the date of my signature below. Please release the following information as marked regarding:

- |   |  |
|---|--|
| <input type="checkbox"/> All Medical Records          | <input type="checkbox"/> Skin Prick Test Results   |
| <input type="checkbox"/> Spirometry                   | <input type="checkbox"/> Specific IgE Test Results |
| <input type="checkbox"/> Pulmonary Function Testing   | <input type="checkbox"/> All Laboratory Reports    |
| <input type="checkbox"/> Allergy Extract Prescription | <input type="checkbox"/> Sinus CT or X-rays        |
| <input type="checkbox"/> Other: _____                 |  |

**Transferring  
To:**

Lone Star Allergy & Asthma Center  
C/o Sven Wust, M.D.  
3304 Colorado Blvd., Suite 201  
Denton, TX 76210-6873

Tel: (940) 565-5900  
Fax: (940) 565-0700  
[www.lsallergy.com](http://www.lsallergy.com)

\_\_\_\_\_  
Signature (patient, parent or legal guardian)

\_\_\_\_\_  
Date of Request