DFW Allergist

Dr. Zachary W. Marshall, M.D.
205 N Oak St Ste B, Roanoke, TX 76262

Phone: (682) 593-9355 Fax: (608) 713-8024
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PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS TO DFW ALLERGIST (ZACHARY W. MARSHALL, M.D.)

• Patient Name: ____

• Patient Date of Birth: ______________________________ SSN (optional): ____________________________

I hereby authorize DFW Allergist (Zachary W. Marshall, M.D.) to request confidential health information about me from the entity or person(s) or listed below:

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• Contact address, phone, and fax of the entity/person sending medical records to DFW Allergist:

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• Please send medical records for the follow years or dates: ____

• Please send all relevant medical records including (please check all that apply):

__ Physician Notes __ Diagnostics (PFTs etc.) __ Labs __ Imaging

__ Entire Chart __ Other: _____________________________________

• The purpose of this request is for (please check one):

__ Continuation of medical care __ Other: ____________________________

I, the undersigned, hereby authorize and consent to the release of my confidential medical records to DFW Allergist (Zachary W. Marshall, M.D.). Unless revoked in writing, this request expires 1 year from the date of my signature. I authorize the use of a copy of this release and consent in place of the original document.

• Please fax these medical records to (608) 713-8024. If unable to be faxed, the mailing address is: DFW Allergist, 205 N Oak St Unit B, Roanoke, TX 76262. Please call (682) 593-9355 with questions.

• Patient Printed Name: ____

• Signature: ____ • Today's Date: _______________________

• Signature of Parent/Guardian (if a minor): ____

• Relationship of Parent/Guardian to Patient (if a minor): ____