ALLERGY ASTHMA
CENTER OF AUSTIN

William C Howland III, MD
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REQUEST FOR MEDICAL RECORDS

Date:________________________________ FAX RECORDS TO: 512-345-1649

To:__________________________________

Address:_____________________________ OR MAIL RECORDS TO:

City/State/Zip_________________________ Allergy and Asthma Center of Austin

11645 Angus Rd, A1

Dear_________________________________: Austin, TX 78759

Please provide the medical information requested below pertaining to my medical care in your office from ________________ to date. Thank you for your prompt response to my request.

____
Patient/Legal Guardian Signature

PLEASE PRINT:

Patient Name: ____

Parent's Name: ____

Patient's Previous/Maiden Name:____

Patient's Birthdate:__________________ Social Security Number: _______________________

Patient's Chart Number (*if Available)*:__________________________

Approximate period of care: ____________________ to ____________________ (dates).

THE FOLLOWING RECORDS ARE REQUESTED:

_________ Initial History and Physical
_________ Hospital Discharge Summary
_________ X-Ray Reports _______________
_________ Laboratory Reports
_________ Brief Summary of Office Care
_________ All Skin Test/RAST Results
___________ Progress Notes
___________ Consultation Reports
___________ Pulmonary Function Studies
___________ Extract Formula

Please include specific antigens, concentration, volume, and supplier. Your cooperation is greatly appreciated. Thank you helping us to provide appropriate continuing care to this patient.