THE Woodlands Allergy
ASTHMA & IMMUNOLOGY CENTER

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TRANSFER OF MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone number: _____

I request the transfer of my medical records FROM:

_____

Fax: _____

Tel: _____

TO the following Physician/Clinic:

_____

Fax: _____

Tel: _____

Send the following items:

- □ Office notes
- □ Imaging/Radiology reports
- □ Lab results
- □ Skin testing results
- □ Immunotherapy record
- □ Emergency Room visit
- □ History and Physical
- □ Operative/Procedure report
- □ Discharge summary
- □ Entire medical record
- □ Other _____

Date: _____ **Signature:** _____