Authorization to Release Medical Records

I hereby authorize The Allergy & Asthma Center P.C. to release medical records & data pertaining to :

Patient Name:_____ S.S. #:_____

Date of Birth:_____ Phone #:_____

Street Address:_____ City,State,Zip:_____

Please specify what records should be released:

_____ All records

_____ All records between the dates of_____and_____

_____ Records pertaining to _____

Please specify method of release:

_____ Pick-up

_____ Mail to:

Name:_____ Title/Buisness:_____

Street Address:_____ City, State,Zip:_____

Phone #:_____ Relationship to patient:_____

Patient /Guardian Signature:_____ Date:_____

Internal use only:

Completed By:_____

Date Records Mailed/Picked-up:_____