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MEDICAL RECORDS RELEASE

Patient Name: _____

Patient Address: _____

Date of Birth: _____

The undersigned hereby authorizes Allergy & Asthma Care, PA. to (choose one or both)

_____ release or _____ obtain records or exchange verbal information with the following facility/person:

Name _____
Street Address _____
City, State, Zip _____
Phone Number _____ Fax Number _____

Records requested: _____

Reason for record request: _____

Signature of Patient _____ Date _____

Signature of parent, guardian or authorized representative _____ Date _____

Address & City, State, ZIP _____
Phone _____

Signature of Witness _____ Date _____

This authorization will expire one year from date signed and may be revoked in writing by the patient or patient's representative.