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MEDICAL RECORDS RELEASE

Patient Name: _____

Patient Address: _____

_____

Patient Phone: _____

Date of Birth: _____

The undersigned hereby authorizes Allergy & Asthma Care, PA. to:

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

_____ obtain records from 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: _____

****

_____	_____	_____
(patient's name)	*(patient signature)*	*(date)*
_____	_____	_____
(parent or guardian)	*(parent/guardian signature)*	*(date)*
_____	_____	_____
(witness)	*(witness signature)*	*(date)*

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