Request for Release of Medical Information

Allergy and Asthma Medical Group and Research Center, A PC
5776 Ruffin Road
San Diego, California 92123
Phone 858.292.1144 / Fax 858.268.5145

Patient's Full Name: ____ D.O.B. _______________

Patient's Home Address: ____

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Description of Records Requested (please check all that apply):

- ☐ Allergy Skin Testing
- ☐ Allergy Injection Record
- ☐ Summary Letter
- ☐ Contents of Allergy Injection Treatment Extracts (Recipe)
- ☐ Labs
- ☐ X-Ray/CT Reports
- ☐ Chart Notes
- ☐ All Records

I, ____ hereby authorize:

Allergy and Asthma Medical Group and Research Center, A PC

To release the above indicated information to:

____
Full name of entity to receive medical records

____
Their complete mailing address

____

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature: ____

Relationship to the patient: ____________________________________Date: _______________________

Unless otherwise revoked, this authorization expires[1] on:__________________________________ .
(Expiration event or date)

________ I authorize Allergy and Asthma Medical Group and Research Center to fax the requested
(initials) records to the following **fax number** (________) _________________________ .

For office use:
Date mailed: __________________
Date picked up: ________________
Date faxed: ___________________

[1] If no date is indicated, this authorization will expire 12 months after the date of signing this form.