ALLERGY ASTHMA
& IMMUNOLOGY ASSOCIATES, LTD

Fax completed form
to (480) 949-8339

MEDICAL RECORDS RELEASE

Patient Name_____DOB_____
Address_____
City_____ State_____ Zip Code_____ Phone _____

Release to:
Physician/Facility_____
Address_____
City_____ State_____ Zip Code_____
Phone _____ Fax_____

Release From:
Physician/Facility_____
Address_____
City_____ State_____ Zip Code_____
Phone _____ Fax_____

Release information between _____ and _____
(Date) (Date)

Release the following (circle all that apply)

Chart Notes	Lab Reports
Skin Tests	Injection Schedule
X-Ray/Pulmonary Tests	Other_____

Reason for release_____

I authorize the release of HIV/AIDS test results. Yes No Initial_____

I authorize the release of all information indicated, and I am aware that the records release may contain information relating to psychiatric, emotional or sexual conditions, physical abuse, or drug and alcohol abuse.

_____
Signature of Patient, parent or legal guardian **Date**

_____
Witnessed by **Date**

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.