ALLERGY ASTHMA & IMMUNOLOGY ASSOCIATES, LTD

Medical Records Release

Patient Name: _____ DOB: _____

Release to/from: Allergy Asthma & Immunology

North Scottsdale	Old Town	Gilbert
10200 N 92nd street Suite 130	7514 E Monterey Way Suite 1	3370 S Mercy Road Suite 303
Scottsdale, AZ 85258	Scottsdale, AZ 85251	Gilbert, AZ 85297
P: (480)614-8011 F: (480)949-8339	P: (480)949-7377 F: (480)949-8339	P: (480)946-8174 F: (480)949-8339

I authorize the release of my medical records to/from:

Doctor/Facility/Individual: _____

Phone: _____

Fax: _____

Release information between (years): _____ and _____

Please release the following information:

Chart Notes Lab Reports Skin Tests All

Injection Schedule X-Ray Pulmonary Test Other: _____

I authorize the release of all my information indicated and I am aware of the records being requested

_____ _____

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

Reach Susana with medical records at (480)889-6320