The Allergy & Asthma Clinic
Peninsula Allergy and Asthma Associates
Andrew C. Engler, M.D. *Bhushan C. Gupta, M.D.* *Betty Miller, M.D.*
Brooke Leon, N.P.

REQUEST FOR RELEASE OF MEDICAL INFORMATION
Please allow up to 14 business days to process

Patient's Full Name: _____ **D.O.B.:** _____

Patient's Home Address: _____

_____

_____

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

- ☐ **Allergy Skin Testing**
- ☐ **Allergy Injection Record**
- ☐ **Summary Letter**
- ☐ **Contents of Immunotherapy Vaccine**
- ☐ **Spirometry/Exhaled Nitric Oxide**
- ☐ **Labs**
- ☐ **X-ray/CT reports**
- ☐ **Chart Notes**
- ☐ **All Records**
- ☐ **Allergy Vials**
- ☐ **Dosing Instructions**
- ☐ **Informed Vienne**

I, _____ **hereby authorize:**

The Allergy & Asthma Clinic and/or Peninsula Allergy and Asthma Associates

To release the above indicated information to:

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

If the patient is a minor, please fill out the following:

_____ _____ _____
Child's Name **Parent Signature** **Date**

OFFICE USE:
Date Mailed: _____
Date Pick Up: _____
Date Faxed: _____

290 Baldwin Avenue San Mateo, CA 94401 *1800 Sullivan Ave., Ste 502, Daly City, CA 94015*
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