The Allergy & Asthma Clinic
Peninsula Allergy and Asthma Associates

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CONSENT TO RELEASE MEDICAL RECORDS FORM
Please allow a Minimum of 14
Working/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**	☐ **Labs**	☐ **Taking Vials w/ me**
☐ **Allergy Injection Record**	☐ **X-ray/CT reports**	☐ **Allergy Vials**
☐ **Summary Letter**	☐ **Chart Notes**	☐ **Dosing Instructions**
☐ **Contents of Immunotherapy Vaccine**	☐ **All Records**	☐ **Informed Vienne**
☐ **Spirometry/Exhaled Nitric Oxide**	☐ **Date of Appt._____**	

I, _____ hereby authorize:

The Allergy & Asthma Clinic and/or Peninsula Allergy and Asthma Associates
Release above indicated information to: (If a physician, please include Address, Tel & Fax numbers)

_____

_____

_____

_____

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:_____

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