allergy asthma immunology associates

RELEASE OF INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I, _____, authorize Allergy, Asthma, & Immunology Associates, PC to release the following medical information:

___ History & Physical Exams, office notes

___ Radiology studies (CT scans, X-rays, etc)

___ Pulmonary Function Tests

___ Biopsies, pathology reports

___ Laboratory Studies (blood tests, urine tests, etc)

___ Previous allergy skin tests

___ Allergy immunotherapy formula ("the allergy shot formula")

___ Previous vial sheets

___ Other:

Please release this information to:

Name:

Address:

Fax number:

Patient signature Date

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