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RECORDS RELEASE FORM

Date: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

TO: _____

_____

I hereby authorize the above named physician(s), hospital or other medical institution to furnish to Allergy and Rheumatology Medical Clinic the information checked below:

( ) Laboratory Data

- Blood-work
- Pathology reports

( ) Radiology Data

- X- Ray results
- MRI/CT results

( ) History and Physical

- Most recent office visit notes

Special requests: _____

Kindly do not fax any records over 10 pages in length.