SAN TAN Allergy & Asthma

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (please print)**:**

Name: ____Dob:______________________________

Address: ____

Signature:____Date:______________________________

____Date:______________________________
Parent or guardian signature: (if patient is under 18)

☐ Please request records from the following physician:
☐ Please release my records to the following physician:

Physician:____

Phone number:____________________________________Fax:_______________________________________

Address: ____

City: ____State:______________Zip code:________________

And

Physician:____

Phone number:____________________________________Fax:_______________________________________

Address: ____

City: ____State:______________Zip code:________________

Records to be released or requested:

______results of allergy tests, lab tests, CT's pertaining to your treatment
______all medical records
______only the following:____