

S. Reed Shimamoto, MD • Neal Jain, MD • Jennifer Hill, MD

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)

REQUEST records from the following: **RELEASE** San Tan Allergy & Asthma's records to the following:

Physician: _____

Phone number: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip code: _____

Records pertaining to allergy/asthma/immunology

All medical records

Only the following: _____

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