Saint Clair Allergy and Asthma Center
50505 Schoenherr Rd Suite 350
Shelby Twp, MI 48315
586-884-5656

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

By signing below, I hereby authorize **Saint Clair Allergy and Asthma Center** to obtain the Medication History related to the patient above for the purpose of Continued Treatment.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.

_____
Date of Authorization

_____
Printed Name: Patient/Legal Representative or Guardian

_____
Signature: Patient/Legal Representative Guardian

May 2014