Saint Clair Allergy and Asthma Center, PLLC

RECORDS RELEASE FORM

Patient's Name: _____ Date of Birth:_____

Physician/Hospital Name: _____

Physician/Hospital Address: _____

_____

_____

Please release the medical records regarding the above patient to:

_____ 50505 Schoenherr Rd
Suite 350
Shelby Township, MI 48315-3141
Phone: 586-884-5656
Fax: 586-884-5674

____ 25200 Little Mack
St. Clair Shores, MI 48081
Phone: 586-884-5656
Fax: 586-884-5674

_____ From **Saint Clair Allergy & Asthma Center, PLLC** to: _____

_____

_____

We are especially interested in the following information:

____ X-ray Reports

____ EKG Reports

____ Laboratory Reports

____ Summary of Clinical Impression

____ Allergy Test Reports

____ Contents (formula) of Allergy Extracts used in Immunotherapy

____ Other _____

I hereby authorize the release of my medical records as provided above.

_____ _____

Patient's Signature Date