Medical Records Release Form

Patient Name: _____ Patient DOB: ___/____/____

I, _____ hereby authorize and request Allergy, Asthma, and Immunology Innovations to send records to _____.

Please send the following items:

- ☐ Office notes
  - ☐ Most recent
  - ☐ 3-6 months of notes
  - ☐ 6+ months of notes
- ☐ Labs
  - ☐ Most recent labs
  - ☐ All labs
- ☐ Imaging
  - ☐ _____
- ☐ Other
  - ☐ _____

Patient/Guardian Signature: _____

Date: ___/____/___

Witness Signature: _____

Allergy, Asthma, and Immunology Innovations

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