DESERT CENTER FOR ALLERGY AND CHEST DISEASES

Today's date: ___________________

THERE IS A $25 CHARGE FOR PREPARING MEDICAL RECORDS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Desert Center for Allergy and Chest Diseases to release medical records and data pertaining to:

Patient Name ______________________________ DOB ____________

Pt Phone Number ______________________________

Reason for records release ____

Please specify what records should be released:

____ All Records

____ Other ______________________________________

Records are being released to:

____

Please specify method of release:

_____ Pt Pick-up _____ Fax Destination fax #: ________________________________

_____ Mailing Address ____

Please be aware that if there are more than 15 pages, records cannot be faxed.

Patient/Guardian signature ____

6970 E. Chauncey Ln #100
Phoenix, AZ 85054
(602) 788-7211 FAX (602) 788-1890