



**Allergy & Asthma  
Associates  
of Southern California**

Leading-edge, personalized care you can trust

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**Authorization to Release Medical Records**

I hereby authorize **ALLERGY AND ASTHMA ASSOCIATES** to release medical records and data pertaining to:

Subject Name:	Social Security Number:
Date of Birth:	Phone Number:
Street Address:	City, State, Zip Code:

*Please specify what records should be released:*

- All records
- All records between the dates of \_\_\_\_\_ and \_\_\_\_\_
- All records pertaining to \_\_\_\_\_

*Please specify method of release:*

- Pick-up
- Fax to \_\_\_\_\_
- Mail to \_\_\_\_\_

*Reason for transfer* \_\_\_\_\_

Name:	Title/Business:
Street Address:	City, State, Zip Code:
Phone Number:	Relationship to Patient:

**\*\*Please note there will be a charge of \$20 for any personal copies of records that cover more than one date of service\*\***

Subject/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

*Internal use only:*

Completed By: \_\_\_\_\_

Date records faxed/mailed/picked-up: \_\_\_\_\_

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