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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