4840 E. Indian School Rd. Suite 101
Phoenix, AZ 85018
Ph (480) 626-6600 Fax (480) 626-6604

S. Reed Shimamoto, MD • Neal Jain, MD • Jennifer Hill, MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (please print)**:**

Name: ____DOB:___________________________

Address: ____

Signature:____Date:___________________________

____Date:___________________________

Parent or guardian signature: (if patient is under 18)

☐**REQUEST** records from the following: ☐**RELEASE** Arcadia Allergy & Asthma's records to the following:

Physician:____

Phone number:__________________________________Fax:_____________________________________

Address: ____

City: ____State:______________Zip code:________________

☐ Records pertaining to allergy/asthma/immunology
☐ All medical records
☐ Only the following:____

☐**REQUEST** records from the following: ☐**RELEASE** Arcadia Allergy & Asthma's records to the following:

Physician:____

Phone number:__________________________________Fax:_____________________________________

Address: ____

City: ____State:______________Zip code:________________

☐ Records pertaining to allergy/asthma/immunology
☐ All medical records
☐ Only the following:____