Richmond Allergy and Asthma Specialists, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize and give my consent to:

_____

_____

_____

To release a copy or a summary of all medical records regarding:

_____
(Name of Patient)

_____
(Date of Birth)

_____
(Social Security Number)

To be sent to:

Richmond Allergy and Asthma Specialists, P.C.
Independence Park
9920 Independence Park Drive, Suite 100
Henrico, VA 23233
Telephone (804) 285-7420 **Fax (804) 285-7454**
www.richmondallergy.com

Records Requested: _____

Purpose for disclosure: _____

My signing of this release is voluntary. I can inspect or copy any information disclosed under this release. I will be provided a copy of this release. I understand that there ***may*** be a fee for medical records representing clerical time, photocopying, paper, and postage.

Signature: _____

Patient Relationship: _____

Date: _____ Telephone: _____