South Bay Allergy & Asthma Associates

20911 Earl Street, Suite 301, Torrance, CA 90503
Ph 310-371-1388 Fax 310-371-3439

Authorization for Medical Records Request

I hereby authorize ___________________________________ to release my medical records and data to **South Bay Allergy & Asthma Associates**.

Records requested from:

______________________________ ____________________ ____________________
Physician Name Phone Number Fax Number

I am requesting the following records:

- ☐ Complete medical record
- ☐ Progress/visit notes
- ☐ CT scan and/or X-ray results
- ☐ Allergy skin test results
- ☐ Serum formula for immunotherapy
- ☐ Current immunotherapy schedule
- ☐ Other ___________________________

______________________________ _________________ _______________________
Patient Name Date of Birth Phone Number

______________________________ _________________
Patient/Guardian Signature Date

Internal Use Only

_________________________ _________________________ *Request sent via: Fax Email Mail*
Completed by *Date*