South Bay Allergy & Asthma Associates

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

Authorization to Release Medical Records

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

_____	_____	_____
(Physician) Name	(Physician Phone Number)	(Physician Fax Number)

I am requesting the following records to be sent:

- □ 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 _____

Mode of records release:

□ Pick up □ Mail □ Fax □ Email

_____	_____	_____
Patient Name	Date of Birth	Phone Number

_____	_____
Patient/Guardian Signature	Date

Internal Use Only

_____	_____
Completed by	*Date*