South Bay Allergy & Asthma Group
A Medical Corporation

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AUTHORIZATION FOR RELEASE MEDICAL INFORMATION

This authorization to release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act (California Civil Code, Section 56, et. Seq.). The purpose of this request is to make available medical information to continue care for:

Please Print:

_____
Name of Patient

_____
Date of Birth

_____
Telephone Number

I authorize the release of any discussion relating to all medical information, including Initial History, Physical and Progress notes for the last seven (7) years and the following:

☐ Correspondence
☐ Pulmonary Function Tests (PFT sheet)
☐ Allergy Injection record (immunotherapy) 1st and last page
☐ Lab/EKG
☐ X-Ray
☐ Other_____

Records Requested From:

_____
Name of Physician/Clinic

_____
Address

_____
City, State, Zip Code

_____
Telephone Number

Send Records To:

_____
Name of Physician/Clinic

_____
Address

_____
City, State, Zip Code

_____
Telephone Number

This authorization shall be effective on _____and shall remain in effect indefinitely.

_____
Signature of Patient/Parent or legal guardian

_____
Date

We are allowed 14 days from date of request to copy records.
There will be a $15.00 charge for medical records to self, immediate request, or patient pickup.