

**THE ALLERGY AND ASTHMA CLINIC**  
**ANDREW C. ENGLER, M.D.**  
**BROOKE LEON, N.P.**

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**MEDICAL RECORD RELEASE TO ANOTHER M.D.**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Phone #: \_\_\_\_\_

REASON FOR REQUEST

Relocating/Transferring to New M.D. \_\_\_\_\_ Concurrent Treatment with Another M.D. \_\_\_\_\_

**If you are relocating, please provide your forwarding information here:**

Forwarding Address: \_\_\_\_\_  
\_\_\_\_\_

New Phone #: \_\_\_\_\_

***I hereby authorize Dr. Engler or any agent of The Allergy & Asthma Clinic to disclose any and all types of medical information, including laboratory and x-ray results via mail or fax machine, to the following physician:***

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
\_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Physician's Fax Number: \_\_\_\_\_  
**(Please provide if records are to be sent electronically)**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

***This authorization is valid for one year or until such time as it is revoked by me in writing.  
I understand that I have the right to receive a copy of this authorization.***