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

MEDICAL RECORD RELEASE TO PATIENT (SELF)

Date: _____

Patient Name: _____ Date of Birth: _____

Current Phone #: _____

REASON FOR REQUEST

Relocating/Transferring to New M.D. _____ For Personal Records and History _____

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 release a copy of my medical records, including laboratory and x-ray results via mail to me at:

Address: _____

_____

_____

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.

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