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

Please allow up to 7 business days to process.

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 _____ 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.

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