ALLERGY ASSOCIATES
Of Sarasota & Venice
2650 Bahia Vista St # 304 Sarasota, FL 34239
Phone:(941) 366-9711 Fax: (941) 957-0079
Allergysarasota.net

MEDICAL RECORDS AUTHORIZATION

I hereby request my Medical Records to be:

____ Obtained from: Dr. _____

Address: _____

Phone: _____

Fax: _____

____ Released to: Dr.: _____

Address: _____

Phone: _____

Fax: _____

___ Skin Test
___ Office Visit
___ Immunotherapy Extract
___ Injection Record
___ Lab Results
___ Other

Reason for Release: _____

Patient Name: _____

Signature: _____

Parent/legal guardian: _____

Date of Birth: _____ Date: _____ Expiration Date: _____