ALLERGY ASSOCIATES
Of Sarasota & Venice

Patient Information:

Name:		
Address:		
City:	State:	Zip:
Phone:	Date of Birth:	

Request Medical Information FROM: Allergy Associates Other (fill in information below)

Physician/Practice Name:			
Address:			
City:	State:	Zip:	Phone:

Send Medical Information TO:

Allergy Associates

Sarasota: 1250 S. Tamiami Trail # 302– Sarasota, FL 34239 – 941.366.9711 Fax 941.957.0079

Venice: 400 S. Tamiami Trail # 170 – Venice, FL 34285 – 941.486.0413 Fax 941.485.6408

Other:

Name:		
Address:		
City:	State:	Zip:

Complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to_____.

Reason(s) for Records Request:

Moving out of the area
Insurance Change. New Insurance:_____
Change of provider. Provider Name:_____
Primary physician needs records
Copy for northern physician
Other (please explain):_____

I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This Release of Information will remain in effect until terminated by me in writing.

_____ _____ _____ _____

Patient or Legal Representative Date Witness Date

At Allergy Associates, we consider it a privilege to be entrusted with your care. Please allow 10 business days for processing your request.