SAINT CLAIR ALLERGY & ASTHMA CENTER, PLLC

MEDICAL RECORD REQUEST - RELEASE

PATIENT'S LAST NAME:		FIRST	DATE:
BIRTHDATE:		SOCIAL SECURITY NUMBER:	
STREET ADDRESS		CITY	STATE & ZIP
HOME TELEPHONE: ( )	CELLULAR NUMBER: ( )	EMAIL ADDRESS:	

PHYSICIAN OR HOSPITAL:

NAME	
ADDRESS	
TELEPHONE	
FAX	

PLEASE RELEASE THE MEDICAL RECORDS REGARDING THE ABOVE PATIENT TO:

☐ 50505 Schoenherr Road, Suite 350
Shelby Township, Michigan 48315-3141
Phone: (586) 884-5656
Fax: (586) 884-5674

☐ 25200 Little Mack Avenue
Saint Clair Shores, Michigan 48081
Phone: (586) 884-5656
Fax: (586) 884-5674

☐ **FROM SAINT CLAIR ALLERGY & ASTHMA CENTER, PLLC TO:**

NAME	
ADDRESS	
TELEPHONE	
FAX	

PRIORITY RECORDS OF INTEREST:

☐ **X-RAY REPORTS** ☐ **EKG REPORTS** ☐ **LABORATORY REPORTS** ☐ **SUMMARY CLINICAL IMPRESSION**

☐ **ALLERGY TESTS** ☐ **CONTENTS (FORMULA) ALLERGY EXTRACTS USED FOR IMMUNOTHERAPY**

☐ **OTHER:**

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS DIRECTED ABOVE:

PATIENT/GUARDIAN SIGNATURE	DATE: