Ashburn Allergy

MEDICAL RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MEDICAL RECORDS TO:

NAME: ASHBURN ALLERGY, PLLC

ADDRESS: 20955 PROFESSIONAL PLZ STE 300

ASHBURN, VA 20148

PHONE: (571) 246-6323

FAX: (888) 823-5456

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING THE DIAGNOSIS AND/OR TREATMENT, OF THE PATIENT LISTED BELOW, DURING THE PERIOD FROM _____ TO _____.

NAME: _____

DATE OF BIRTH: _____

COMMENTS: _____

SIGNATURE: _____

PARENT/GUARDIAN IF MINOR