MASA
MIDWEST ALLERGY SINUS ASTHMA SC

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RECORDS RELEASE AUTHORIZATION

Name: _____ **DOB:** _____

I hereby authorize and request the release of the following:

_____ All Records _____ Progress Notes _____ Laboratory Results

_____ X-Ray Reports _____ Skin Testing _____ PFT Results

Authorization give to:

_____

_____

_____

_____

Release to:

Midwest Allergy Sinus Asthma S.C.
2010 Jacobssen Dr.
Normal, Il 61761
Fax: (309) 862-0961

2151 W. White Oaks Dr.
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I understand that I have the right to read and or copy the information to be disclosed for the required fee. I also understand that I have the right to revoke this consent by written statement at any time, otherwise it will automatically expire 90 days from the date of authorization. I understand that information will not be released if I refuse to sign this form.

_____ Date:_____
(signature of patient or legal representative)

_____
(relationship to patient)