Bloomington-Normal Office 309-452-0995
Springfield Office 217-717-4404
Satellite Offices: Carlinville-Morton-Sherman-Jacksonville-Taylorville

REQUEST FOR MEDICAL RECORDS AND RELEASE AUTHORIZATION

Name: _____ DOB: _____
For the purpose of initiating care or continuing my care with Midwest Allergy Sinus Asthma, I hereby authorize and request the release of the following medical records:

Authorization given to:_____

Address:_____Tel / Fax:_____

▫All Records	▫Allergy Skin Tests	▫Pulmonary Function Testing	▫Laboratory Results
▫Progress Notes	▫Allergy Shot Records	▫X-ray/Diagnostic Reports	▫Other:

For the following time interval:

▫Past 12 months	▫All Records	▫Other:

From the following physicians/care providers:

▫ Dr.	▫All Care Providers at Your Facility

Release to:

▫Dana Dalbak PAC	▫Caitlyn Fox FNP	▫Dr Robert Kaufmann
▫Kathleen Lally FNP	▫Tamara Reeter, CNP	▫Dr. Dareen Siri FAAAAI FACAAI FISAAI

Midwest Allergy Sinus Asthma S.C., Email: administrativestaff@asthma2.com

▫ 2010 Jacobssen Dr., Normal, Il 6176 **Tel: 309-452-0995 Fax: (309) 862-0961**

▫ 2151 W. White Oaks Dr., Springfield, Il 62704 **Tel: 217-717-4404 Fax: (217) 718-5284**

- ▫ At Carlinville Area Hospital, 20733 North Broad Street, Carlinville, IL 62626
- ▫ At HSHS Medical Office Building, 1745 W. Walnut Street, Jacksonville, IL 62650
- ▫ At 652 W. Jackson St., Morton, IL 61550
- ▫ At HSHS Sherman, 2806 E. Andrews Rd., Sherman, IL 62684
- ▫ At HSHS Multispecialty Care, 1304 W Burnett Dr, Taylorville, IL 62568

I have the right to read and/or copy the information communicated above for the required fee. I have the right to revoke this consent by written statement at any time. This release will otherwise expire 90 days from the date of authorization. Information may not be released if I do not sign this form.

_____ _____ _____

Printed Name Patient or Parent/Guardian Signature Date