Bloomington-Normal: 309-452-0995
Springfield: 217-717-4404
Fax: 309-862-0961
Satellite Offices: Carlinville -Jacksonville
www.asthma2.com

REQUEST FOR MEDICAL RECORDS AND RELEASE AUTHORIZATION

Name: _____ DOB: _____

I hereby authorize and request the release of the following medical records from:

- ▢ **Midwest Allergy Sinus Asthma, SC**
- ▢ **Other:**

Provider/FacilityName:_____

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:

Release to:

- ▢ **Midwest Allergy Sinus Asthma, SC**
  - ▢ 2010 Jacobssen Drive, Normal IL 61761; Fax: 309-862-0961
  - ▢ 2151 W. White Oaks Drive, Springfield, IL 62704; Fax: 309-862-0961
- ▢ **Other:**

Provider/Facility Name:_____

Address:_____Tel / Fax:_____

- ▢ **Self:**

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