Associated Allergists and Asthma Specialists, LTD
10733 W. 165th Street
Orland Park, IL 60467

CONSENT FOR RELEASE OF MEDICAL RECORDS

Associated Allergists *Office Location* Records Requested from: ___________________________

Doctor: _______________________________________

Date: ___/____/____

Patient Name: ______________________________ Date of Birth: ___________________________

Person requesting records: _____________________________Relationship: __________________

Daytime phone number: _______________________________

I hereby request that all medical records be released from (date)________ to __________.

Please forward records to:

____

____

____

____

Signature of patient or parent/legal guardian if minor:

____

* Please include copy of photo ID along with completed form.