FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.
ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY
DIPLOMATES OF THE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

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G. CALLA MOORE, A.P.R.N.

RECORDS REQUEST

Date _____

Please provide all information Fairfield County Allergy, Asthma & Immunology Associates has requested pertaining to my medical records as designated below:

Patient's Name (print)_____

Date of Birth: _____

Patient's Previous or Maiden Name if applicable: _____

Approximate Period of Care: _____ to _____

The following records are requested:

____ History and Physical
____ Discharge Summary
____ Consultation Reports
____ Progress Notes or Summary
____ Laboratory Reports
____ All Skin Test/RAST Results
____ Exact Composition Allergenic Extract; Antigens, Concentration and Manufacturer
____ Radiology Reports: X-Ray, MRI, CT scan, etc.
____ Pulmonary function studies
____ All Records

Patient/ Parent's signature: _____

Thank you.