FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.
ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY
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G. CALLA MOORE, A.P.R.N.

# RECORDS REQUEST

Date _____

Please provide all information 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

Fax number to where medical records should be sent: _____

**Full Name & Address where records should be mailed**:

Name_____

Address: _____

City/State/Zip: _____

Patient/ Parent's signature: _____

*Please allow up to two weeks for the record request to be fulfilled. *

NORWALK OFFICE: 148 EAST AVENUE, SUITE 3G, NORWALK, CT 06851 • (203) 838-4034 • FAX (203) 853-6361
GREENWICH OFFICE: 2½ DEARFIELD DRIVE, SUITE 201, GREENWICH, CT 06831 • (203) 838-4034 • FAX (203) 869-1056
STAMFORD OFFICE: 80 MILL RIVER STREET, SUITE 2100, STAMFORD, CT 06902 • (203) 838-4034 • FAX (203) 357-1743
RIDGEFIELD OFFICE: 30 PROSPECT STREET, SUITE 300, RIDGEFIELD, CT 06877 • (203) 838-4034 • FAX (203) 853-6361