FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.

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DIPLOMATES OF THE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

RECORDS RELEASE

Date:

I hereby authorize you to release to _____, the medical records of _____, including history, all records of treatments, laboratory findings, diagnoses and recommendations for the time _____ have/has been under the care of Fairfield County Allergy, Asthma & Immunology Associates.

Please mail this information to me at the address shown below or forward to:

_____

_____

_____

_____

Signature

_____

_____

Address

_____

Witness

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