RECORDS REQUEST TO FCAAIA


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

ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

DIPLOMATES OF THE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

148 EAST AVENUE, SUITE 3G NORWALK, CT 06851 (203) 838-4034

MITCHELL R. LESTER, M.D.
MARK D. LITCHMAN, M.D.
AYMERIC LOUIT, M.D.
AGNES MATCZUK, M.D.
JOSEPH SPROVIERO, PH.D., M.D.
AUDREY BREGANTE, C.P.N.P.


DATE: _____

Please provide all information FCAAIA may request pertaining to my medical records, including laboratory studies and radiology reports as designated below:

_____ _____

Patient/Parent's Name (Print) Patient/Parent's Signature

PATIENT'S NAME: _____ PARENT'S NAME: _____

PATIENT'S PREVIOUS OR MAIDEN NAME: _____

DATE OF BIRTH: _____

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

Your Cooperation is appreciated. Thank you.