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

Date: _____

I hereby authorize you to release to _____
(name)

the medical records of _____ including history, all records of treatments, laboratory findings, diagnosis and recommendations for the time _____ have/has been under the care of Fairfield
(dates)
County Allergy, Asthma & Immunology Associates.

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

_____

_____

_____

_____
Signature

_____

_____
Address

_____
Witness