Allergy & Asthma

Medical Group and Research Center, A P.C.

5776 RUFFIN ROAD, SAN DIEGO, CA 92123 (858) 268-2368 / FAX (858) 268-5147
AAMGRC@ALLERGYANDASTHMA.COM
WWW.ALLERGYANDASTHMA.COM

Alexander N. Greiner, MD, CPI
Director, Principal Investigator

Request for Release of Medical Information

Patient's Full Name:_____ **DOB**:_____/_____/_____
Patient's Home Address:_____
Description of Records Requested (please check all that apply):

- ☐ All Records dated: _____
- ☐ Other _____dated: _____

I,_____,hereby authorize:
(Patient or Parent Name if Patient a minor)

- ☐ Rady Children's Hospital, Fax 858-966-8527
- ☐ Allergy & Asthma Medical Group and Research Center, A PC (AAMGRC)
- ☐ Other *(Please enter Full Name of Physicians Office, Complete Mailing Address and fax # below)*

_____

_____

To release the above indicated information to:

- ☐ Allergy & Asthma Medical Group and Research Center, A PC (AAMGRC)
  ATTN: _____, AAMGRC RCH Dept
  5776 Ruffin Road, San Diego, California 92123
  Phone 858.268.2368 / Fax 858.268.5147
- ☐ Other *(Please enter Full Name and Complete Mailing Address)*

_____

_____

I authorize the above-named entity to fax the requested records to AAMGRC _____
(initials)

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature:_____

Relationship to the patient:_____ **Date**:_____/_____/_____

Unless otherwise revoked, this authorization expires on:_____/_____/_____
If no date is indicated, this authorization will expire 1 year from the date of signing this form.