ADULT & PEDIATRIC ALLERGIST OF CENTRAL JERSEY

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REQUEST FOR RELEASE MEDICAL RECORDS

Date: _____

To: _____

_____

_____

I hereby authorize and request you to release:

Patient Name: _____
Date of birth: _____

My complete medical records in your possession, including:
_____ Progress Notes
_____ Consultation Letter
_____ Skin Testing
_____ Immunotherapy records (including Manufacturer)
_____ Laboratory results
_____ Others

To: ADULT & PEDIATRIC ALLERGIST OF CENTRAL JERSEY

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Patient's signature: _____