Allergy & Asthma Associates of Southern California

Leading-edge, personalized care you can trust

REQUEST FOR RELEASE OF MEDICAL RECORDS

Use this form when you want to transfer records
to our office from a different office.

PLEASE PRINT - THANK YOU!

PREVIOUS DOCTOR: _____

ADDRESS: _____

_____

_____

TELEPHONE/FAX#: _____

☐ All Medical Records (including lab results, visit notes, and procedures)

☐ Date Range:_____ to _____

PLEASE FORWARD A COMPLETE COPY OF MY MEDICAL RECORDS
INCLUDING ALLERGY TEST RESULTS AT MY REQUEST TO
ALLERGY & ASTHMA ASSOCIATES OF SOUTHERN CALIFORNIA
27800 MEDICAL CENTER ROAD #244
MISSION VIEJO, CA 92691

PLEASE PRINT - THANK YOU!

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY# _____

SIGNATURE _____ _____
PATIENT, PARENT OR GUARDIAN DATE

PRINTED NAME _____
PARENT OR GUARDIAN (if different from patient)

Expires 1 year of the date of signature but may be revoked sooner if done in writing

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FOR OFFICE USE ONLY:
ACTION: PREPARED BY _____ DATE_____

PLEASE CIRCLE ONE: MAILED FAXED TO BE PICKED UP DATE_____

Mission Viejo · 27800 Medical Center Road, Suite 244 · Mission Viejo, CA 92691
Irvine · 15785 Laguna Canyon Rd., Suite 100 · Irvine, CA 92618
Phone: (949) 364-2900 · **Fax**: (949) 365-0117