PEACHTREE ALLERGY AND ASTHMA CLINIC, P.C.

1800 Peachtree St. NW
Suite 720
Atlanta, GA 30309
404-351-7520
Fax: 404-355-2048

2675 Paces Ferry Rd. NW
Suite 160
Atlanta, GA 30339
678-305-9871
Fax: 678-305-1065

REQUEST FOR MEDICAL INFORMATION

TO: _____

_____

_____

_____

RE: _____
LAST NAME FIRST INITIAL MAIDEN **BIRTH DATE**

_____
ADDRESS

_____
CITY STATE ZIP PHONE

APPROXIMATE DATES TREATED: _____

ADMITTING PHYSICIAN, IF HOSPITALIZED: _____

I AM CURRENTLY BEING EVALUATED BY:

☐ CAROL A. WIGGINS, M.D. ☐THEODORE M. LEE, M.D. ☐ AMY H. HIRSH, M.D. ☐DIANE M. O'CONNOR, A.P.N.P.

YOU ARE HEREBY AUTHORIZED TO RELEASE THE FOLLOWING DATA FROM MY MEDICAL RECORDS:

_____ EVALUATION

_____ X-RAY REPORTS

_____ ACTUAL SKIN TESTS RESULTS (COPY OF TESTING SHEET PREFERRED)

_____ ACTUAL FORMULATION OF TREATMENT EXTRACT AND INJECTION RECORD

_____ ANY OTHER CONSULTATION REPORTS

_____ OTHER (PLEASE SPECIFY) _____

_____

I understand this authorization includes release of all medical records including HIV records, psychiatric/mental illness records, drug, alcohol abuse records, and records of venereal disease and other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that with written notice I may revoke this authorization and consent at any time except to the extent that action has previously been taken in reliance hereof.

PLEASE SEND THE REQUESTED INFORMATION TO THE ATTENTION OF THE PHYSICIAN AT THE FACILITY ABOVE. THANKS FOR ALLOWING US TO HELP WITH THIS PATIENT.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY WITNESS