PEDIATRIC LUNG DISEASES • ASTHMA AND ALLERGIC DISEASES OF CHILDREN AND ADULTS

GERALD C. MOORE, M.D.
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Consent for Release of Medical Records

Patient ____ DOB:______________________

I give my permission for Dr. ____

Address_________________________City_________________St__________Zip_________

Office Phone______________________________Office Fax___________________________

to release information pertaining to the treatment and care of me/my dependent.

Please include the following information:

_______ Chart notes from my office visits

_______ Emergency Room/ Hospital Records

_______ Laboratory Reports/ Test results

_______ Specific immunotherapy prescription, please include breakdown of stock mixes.

This information may be mailed to Dr. Moore at the address below:

____ ________/_______/________

Signature Date

If minor-parent or guardian must sign

____ _________________________________

Relationship to patient Print name of person signing other than patient

____ _______/_______/_________

Witness Date

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