447 Munson Ave
Traverse City, MI 49686
Office: (231) 929-9090 Fax: (231) 929-9092
www.baysideallergy.net

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

I,_____ (D.O.B._____)

hereby authorize the office of

_____

to release my medical records to Bayside Allergy, PC of Traverse City. The purpose of this request is continuation of care.

Please send the following reports:

_____ Office Notes

_____ Labs

_____ X-rays

_____ Other

_____ Testing

Dates of Service _____

Please send or fax records to the above address/fax number at your earliest convenience. Thank you for your assistance in this matter.

Patient/Legal Guardian signature_____Date_____

Witness_____ Date_____