RICHARD R. ROSENTHAL, M.D., LTD.

Adult and Pediatric Allergic Disease, Asthma and Immunology

Diplomates: American Board of Allergy and Clinical Immunology

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RECORDS RELEASE REQUEST

DATE: _____

I hereby authorize **Richard R. Rosenthal, M.D., Ltd.** to release to _____ my current medical information, including the diagnosis and prescribed medications. Please include skin test results, treatment plan, allergy extract components and laboratory test results if applicable.

Name (printed): _____

Signature: _____

Date of Birth: _____

Phone Number: _____

Please specify if additional or special medical records are required:

_____

The fees to prepare your medical record are as follows: a $10 handling fee, a fee of 0.50 cents per page for the first 50 pages and 0.25 cents per page for each page thereafter. Once payment and authorization are received your record will be processed within fifteen business days.

Records are to be ☐ Picked Up _____ Signature _____ Printed Name

☐ Mailed _____ Address for Mailing

_____

☐ Faxed (_____)_____ Fax Number

For office use

Payment: _____ Date: _____

Records completed Date: _____ By: _____