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

☐ Fax Number

For office use

Payment: ____________________________  Date: __________________________

Records completed Date: _______________  By: __________________________

PUBLIC: FORMS PATIENT/RECORD RELEASE APR11