Daniel F. Soteres, MD, MPH
Diplomate of the American Board of Allergy and Immunology

Luke M. Webb, MD
Diplomate of the American Board of Allergy and Immunology

James W. Fulton, MD, MS
Diplomate of the American Board of Allergy and Immunology

Debra Walters, MSNP
Nurse Practitioner - Certified

Wendy Bulow, MMSc, PA-C
Physician Assistant – Certified

Deborah Sweet, FNP-C, MSN
Nurse Practitioner - Certified

Lauren Wieczorek, NP-C
Nurse Practitioner - Certified

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name: ______________________ Former/Maiden name: ______________________
(if applicable)

Birth date: _______ - ______ - _________

Address: ___________________________ City, State: ___________________ Zip: __________

Phone: (________) _________-____________

Authorization to: **RELEASE Medical Records TO Asthma & Allergy Associates**, from:

Name of Physician: ____________________________________

Name of Practice: ______________________________________

Mailing Address: _______________________________________

City, State: _______________________, ________ Zip: _________-________

Fax:_____________________________________

Requested Records to be released (be specific): ☐- Evaluation & Treatment Summary

☐- All records available (E&M Services, notes, X-rays, test results, correspondence, etc).

☐- X-Ray Reports ☐- Skin Test Results ☐- Lab Reports

☐-Extract Recipe ☐- Injection Records ☐- Consultation Reports

☐- Other: (please list here) ____

I hereby release the receiving and releasing parties from any liability which may result from furnishing the information requested. This release will only remain in effect for 180 days (*from date of signature below*) unless revoked in writing at an earlier time.

Signature of Patient *(Guardian of minor child patient)*: ________________________________

Date: ________________

Witness to the above signature: ______________________ Sign: ________________________
(Print name)

A copy of this authorization may be used with the same effectiveness as the original.

Send records to: **Asthma & Allergy Associates, PC**
2709 N. Tejon Street
Colorado Springs, CO 80907

Attn: Medical Records Section