

**BAYSIDE ALLERGY P.C.**

**603 Bay Street  
Traverse City, MI 49684  
Phone: 231-929-9090  
Toll Free: 877-912-9090  
Fax: 231-929-9092**

I, \_\_\_\_\_ D.O.B. \_\_\_\_\_ hereby authorize the

office of \_\_\_\_\_ to release my medical records to the

Bayside Allergy and Asthma of Traverse City. The purpose of this request is continuation of care.

Please send the following reports:

\_\_\_\_\_ Office Notes

\_\_\_\_\_ Labs

\_\_\_\_\_ X-rays

\_\_\_\_\_ Other Testing \_\_\_\_\_

Date 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 signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_