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

# MEDICAL RECORDS RELEASE AGREEMENT FORM

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

hereby authorize the office of Bayside Allergy, PC of Traverse City to release my medical records to

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

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/Legal Guardian signature _____ Date_____

Witness _____ Date_____