

Authorization to Release Medical Records

Hedberg Allergy & Asthma Center

700 South 52nd Street
Rogers, AR 72758
479-464-8887

1585 Rainforest Rd
Fayetteville, AR 72703
479-301-8887

Fax 479-464-9949

I hereby authorize **Hedberg Allergy & Asthma Center, PA** to release medical records and data pertaining to:

Patient Name:	Social Security/MRN:
Date of Birth:	Phone Number:
Street Address:	City, State, Zip Code:

Please specify what records should be released:

- All records
- All records between the dates of _____ and _____.
- Records pertaining to _____

Please specify method of release:

- Pick-up
- Fax
- Certified Mail to:

Name:	Title/Business:
Street Address:	City, State, Zip Code:
Phone Number:	Relationship to Patient:

Patient/Guardian Signature: _____ Date: _____

Internal use only:

Completed By: _____

Date Records Mailed/Picked-up: _____