Authorization for Release Medical Records

Hedberg Allergy & Asthma Center
700 South 52nd Street
Rogers, AR 72758
479-464-8887 ph. 479-464-9949 fax

I hereby authorize _____ 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 & Formulary
- ❑ All records between the dates of _____ and _____.
- ❑ Records pertaining to _____

Please specify method of release:

- ❑ Pick-up
- ❑ Fax
- ❑ Certified Mail to:

Name: Dr. Curtis Hedberg	**Title/Business: Hedberg Allergy & Asthma Center**
Street Address: 700 S 52nd Street	**City, State, Zip Code: Rogers, AR 72758**
Phone Number: 479-464-8887	

Patient/Guardian Signature: _____ Date: _____

Relation to Pt: _____

Internal use only:

Completed By: _____

Date Records Mailed/Picked-up: _____