Pointes Allergy and Asthma Center, P.C.

I, _____, request that any medical record and information from my date of birth to present unless specified otherwise, relating to my care, condition(s), and treatment including history obtained, physical findings, treatments, diagnosis, prognosis, photographs, electronic and digital files and any other records be released to Pointes Allergy and Asthma Center, P.C.

_____ _____

Patient Signature Date

_____

Patient Name Printed

Phone Number _____ Is this a cell phone? **Yes / No**

If yes, will you allow text messages with updates? No medical information will be given.
Yes / No

E-mail_____

Will you allow emails with updates? No medical information will be given.
Yes / No