

SHER ALLERGY SPECIALISTS

11200 SEMINOLE BLVD., SUITE 310

LARGO, FLORIDA 33778

Phone: (727)397-8557

Fax: (727)397-4459

MEDICAL RECORDS REQUEST AUTHORIZATION

I hereby authorize the release of my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

From: _____

Address: _____

City: _____ State: _____ Zip: _____

To: **SHER ALLERGY SPECIALISTS**
11200 SEMINOLE BLVD., SUITE 310
LARGO, FLORIDA 33778

(Patient's Name)

(Patient's Date of Birth)

Signed by: _____
(Signature of Patient or Legal Guardian)

(Relationship to Patient)

(Print Name of Patient or Legal Guardian)

(Today's Date)

This authorization will expire one year from date of authorization or: _____.
{Expiration Date or Defined Event}.