Medical Records Release Form:

I _____ request that my medical record to include only the last two office visits, skin test results, spirometry, recent X-rays, and vaccine sheet (if pertinent), be sent to:

Advanced Allergy and Asthma of Virginia
Barry K. Feinstein, M.D.
5924 Harbour Park Drive
Midlothian, Virginia 23112
Fax Number: (804) 739-9006

Patient Date of Birth: _____

Signature: _____

Date:_____

Email address (optional) : _____