

INTERMOUNTAIN ALLERGY & ASTHMA

150 S. 1000 E.
SLC, UT 84102
(801) 363-4071
(801) 534-1865 (fax)

6065 S. Fashion Blvd. #255
Murray, UT 84107
(801) 266-4115
(801) 266-4138 (fax)

12422 S. 450 E. #C
Draper, UT 84020
(801) 553-1900
(801) 553-9995 (fax)

1682 E. 5600 S.
Ogden, UT 84403
(801) 476-0052
(801) 476-0064 (fax)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: _____

Address: _____

I am soon to be or am currently being evaluated by:

- | | |
|--------------------------------|--------------------------------|
| _____ Joseph R. Anderson, M.D. | _____ Brent R. Burdett, M.D. |
| _____ David S. Gourley, M.D. | _____ Duane J. Harris, M.D. |
| _____ Anthony R. Henry, M.D. | _____ Gregory M. Wickern, M.D. |

and you are hereby authorized to release the following data from my medical records:

- _____ Evaluation and treatment summary
- _____ X-Ray report
- _____ Actual skin test results (copy of testing sheet preferred)
- _____ Actual formula of treatment extract and injection record
- _____ Any other consultation reports
- _____ All medical records on file
- _____ Other (please specify) _____

RE: _____
(last name) (first) (maiden) (middle)

(address) (zip) (phone)

Birthdate _____ Approximate dates treated _____

Admitting physician, if hospitalized _____

Please send requested information to the attention of the physician and facility checked above.
This is a single use authorization that expires upon completion of the request. This authorization may be revoked by sending a written request prior to the expiration event.

(Witness)

(Signature of Patient or Responsible Party)

(Date)

(Relationship to Patient)