

**INTERMOUNTAIN ALLERGY & ASTHMA**

150 S. 1000 E.  
SLC, UT 84102  
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(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)