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Authorization to Release Medical Records

I hereby authorize the release the following information to Eastern Allergy & Asthma Specialists:

- Medical office/consult/procedure notes
- Lab results
- Imaging (e.g. chest x-ray, CT, MRI)
- Allergy skin testing results, immunotherapy records, and flowsheets
- Biopsy results
- Other: _____

Patient Name

Date of Birth

Patient Signature