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DIPLOMATE OF THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

DIPLOMATE OF THE AMERICAN BOARD OF DIAGNOSTIC LABORATORY IMMUNOLOGY

Request for Release of Medical Records

I hereby authorize and consent to have my medical records released:

From: R. Lawrence Siegel, M.D., Ph.D.
17407 Bridge Hill Court, Suite B
Tampa, Florida 33647
(813) 972-3131 – Phone
(813) 972-0773 – Fax

To: _____

_____

_____

_____

Patient's Name: _____
(Please Print)

Patient's Date of Birth: _____

Patient's Signature: _____

If patient is a minor, name and signature of parent/guardian:

_____ _____
(Name – Please Print) (Signature)

Date: _____