SHER ALLERGY SPECIALISTS
11200 SEMINOLE BLVD., SUITE 310
LARGO, FLORIDA 33778
Phone: (727)397-8557
Fax: (727)397-4459

MEDICAL RECORDS REQUEST AUTHORIZATION

I hereby authorize the release of my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

From:____

Address:____

City:___________________________ State: _______Zip: ______________

To: **SHER ALLERGY SPECIALISTS**
11200 SEMINOLE BLVD., SUITE 310
LARGO, FLORIDA 33778

______________________________ ______________________________
(Patient's Name) **(Patient's Date of Birth)**

Signed by:______________________________ ______________________________
(Signature of Patient or Legal Guardian) (Relationship to Patient)

______________________________ ______________________________
(Print Name of Patient or Legal Guardian) (Today's Date)

This authorization will expire one year from date of authorization or:__________________.
{Expiration Date or Defined Event}.