



Northern Colorado
Allergy & Asthma
Clinic, LLC

2121 E Harmony Rd #350
Fort Collins, CO 80528

1130 38th Ave ste A
Greeley, CO 80634

I, _____, do hereby authorize the above named physician at Northern Colorado Allergy and Asthma Clinic to **release** my below noted medical records to:

Please check records to be sent:

- Initial office visit
- Office visit dictation
- Pulmonary Function Test Reports
- Diagnostic Testing: Lab works, X-Rays and CT scans, reports, etc...within the past 5 years
- Allergy Skin Test results
- Consultation reports (reports from outside physicians that we have referred to you. This does NOT include records you have brought to us from physicians you used to practice with).
- Other _____
- All of the above

Please print all info below

_____/_____/_____
(Patient's Name) (Date of Birth) (Today's Date)

_____/_____/_____
(Patient/Guardian signature) (Witness Initials) (Today's Date)

Date records sent _____ / Picked Up _____

By: _____
Pls initial