



CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

RE: Authorization to release medical records for _____ (Patient Name), DOB: _____ SSN: _____.

Dear _____ (Treating Physician):

I am writing to authorize ***Capital Allergy and Respiratory Disease Center*** to obtain my medical records on my behalf. Please release my medical records related to treatment for _____ (Medical Condition) rendered by you or under your supervision from _____ through _____.

Please send my Medical Records to 5609 J Street, Suite C, Sacramento, Ca 95819 or fax to (916) 453-8715.

If you have any questions, please call me at _____ (Patient Phone Number).

Sincerely,

cc: