**TAMPA BAY ALLERGY, LLC**
***a Division of Florida Pediatric Associates***

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**FROM:** Steven G. Weiss, MD, Leah R. Chernin, DO & Constance Bindernagel, DO
3251 McMullen Booth Rd
Clearwater, Fl 33761
727-791-3337 FAX 727-725-2577

Patient _____ Date of Birth _____

Please forward medical records to:

_____

_____

_____

_____

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses.

History /Physical /Notes ___
Skin Tests ___
Immunotherapy recipe ___
Laboratory results ___

Signed _____ Date _____

Witness_____ Date _____