



Allergy & Asthma Center

of Southern Oregon, PC

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RECORDS RELEASE FORM

Patient's Name _____ DOB _____

Physician's Name _____

OR Clinic Name _____

Physician's Address _____

Physician's Phone # _____ Physician's Fax # _____

Please release the medical records regarding the above patient

_____ To: Allergy & Asthma Center of Southern Oregon, PC
3860 Crater Lake Avenue Suite A
Medford, OR 97504
Fax: 541-857-4499 Phone: 541-858-1003

_____ From Allergy & Asthma Center to: _____

Purpose of Disclosure: _____

We are especially interested in the following information:

_____ X Ray reports	_____ EKG reports
_____ Laboratory reports	_____ Summary of clinical impression
_____ Allergy test reports	_____ Contents (formula) of allergy extracts used in immunotherapy

_____ Other: _____

Patient's Signature _____ Date: _____

Medford
Principle Office
3860 Crater Lake Ave. Suite A
Medford, OR 97504

Ashland
Satellite Office
2262 Ashland Street
Ashland, OR 97520

Grants Pass
Satellite Office
1722 Williams Hwy
Grants Pass, OR 97527

Klamath Falls
Satellite Office
2628 Clover Street
Klamath Falls, OR 97603

Roseburg
Satellite Office
1813 W Harvard Avenue Suite 241
Roseburg, OR 97471