



Family Allergy & Asthma Care Consultants, LLC

Shankar Lakhani, MD

Board Certified Allergy & Asthma Care

Diplomate, ABAI, ABP

Renee Cumens, PA-C

Release of Medical Records

Date: _____

Date Sent: _____

By: _____

PATIENT INFORMATION

Patient Name (PRINT) _____

Patient Address: _____

Social Security # _____ Date of Birth _____

Patient/Guardian Signature _____

Witness: _____

Is this release for : (please check one)

_____ personal use(there may be a charge)

_____ medical treatment

_____ transferring, please list reason _____

If for medical treatment please list doctor to which records are to be sent:

Physician's Name _____

Address _____

Phone _____ Fax _____

I hereby authorize Family Allergy & Asthma Care Consultants, LLC to release the following information:

_____ Labs _____ Allergy test _____ Allergy Shot record

_____ PFT's _____ Office notes _____ All Records

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DOVER, DE 19904.

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