COVENANT
Allergy & Asthma Care

Susan P. Raschal, D.O.
DIPLOMATE American Board of Allergy & Immunology

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Telephone Number: _____ **Date of Birth:** _____

Social Security Number: _____

I authorize _____
Name of Physician, Institution

_____
Address

_____
City, State, Zip

_____
Phone

to release and transfer all my medical records to Dr. Susan P. Raschal D.O. at:

Covenant Allergy and Asthma Care, PLLC
1350 Mackey Branch Drive, Suite 114
Chattanooga, TN 37421

I have read or have had read to me, the above statements, and understand them as they apply to me and my medical records.

Signature of Patient or Patient's Legal Representative Date of Signature

_____ _____

Relationship to Patient

_____