Allergy and Asthma Associates, P.A.
James Banks, M.D. & Timothy Andrews, M.D.

Patient Name: _____ DOB: _____

To: _____

_____

_____

I hereby request that you release:

All records
Specific information: _____

_____

_____

To: Allergy and Asthma Associates
277 Peninsula Farm Road
Arnold, MD 21012

Patient/Guardian signature: _____

Date: _____