

Allergy Immunology Clinic of East Bay 2320 Woolsey St/off Telegraph Ave, Berkeley, CA 94705

(925) 270- 5119

I hereby authorize the release of my medical records due to transfer of care:

| | Institute of Integrative Immunology |
|----------------------------------|-------------------------------------|
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| | Fax: (510)666-0916 |
| Please include: | |
| ☐ All paper medical records | |
| ☐ Antigen formula and schedule | |
| ☐ All electronic medical records | |
| ☐ All tests results in-clinic | |
| ☐ All laboratory results | |
| | |
| D. d. | |
| Patient: | |
| | |
| Lost none | Middle initial Date |
| Last name First name | Middle initial Date |
| | |
| | |
| | |
| | |
| Signature | |