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**PERMISSION TO INVOLVE OTHERS IN PATIENT CARE**

I \_\_\_\_\_ am giving Allergy Asthma Specialists, P.A. my permission to involve the below listed persons in my **complete medical care**. The person/persons I am listing will share in my medical care. Allergy Asthma Specialist, P.A. can/will discuss (but not limited to) testing, treatment, results, of my medical care, history, including referred to Physicians/Facilities. This permission includes financial issues involving my care (insurance, co-pays, deductibles, personal balance, bank charges)

Person's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Circle one: **cell home work**

Person's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Circle one: **cell home work**

Person's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Circle one: **cell home work**

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient Name \_\_\_\_\_ Acct # \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Witness Name \_\_\_\_\_ Date: \_\_\_\_\_