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PERMISSION TO INVOLVE OTHERS IN PATIENT CARE

I _____ am giving Allergy Asthma Specialist, PA my permission to involve the below listed people in my **complete medical care**. The person/people I am listing will share in my medical care. Allergy Asthma Specialist, PA 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).

Persons Name: _____ **Relationship:** _____

Phone Number: _____ **Circle one: cell home work**

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Phone Number: _____ **Circle one: cell home work**

Persons Name: _____ **Relationship:** _____

Phone Number: _____ **Circle one: cell home work**

Patient Signature: _____ **Date:** _____

Print Patient Name: _____ **Acct #:** _____

Witness Signature: _____ **Date:** _____

Print Witness Name: _____ **Date:** _____