ALLERGY ASTHMA SPECIALISTS

"Live Allergy Free"

"Treating Children & Adults since 1983"

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, and bank charges).

Persons Name: ______Relationship:_____

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

Persons Name: _____ Relationship: _____

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: _____

Florida Hospital Med Plaza, 661 E. Altamonte Drive, Suite 315, Altamonte Springs, FL 32701. Ph: 407-339-3002. Fx: 407-260-5039
Dr. Phillips Medical Plaza, 7758 Wallace Rd, Suite J, Orlando, FL 32819, Ph: 407-351-4328. Fx: 407 351-1755.
Lake Bennett Medical Center, 1142 Kelton Ave, Ocoee, FL 34761 Ph: 407-219-3620 Fx: 407-347-7586
Lost Lake Village II, 3111 Citrus Tower Blvd, Suite A, Clermont, FL 34711 Ph: 352-243-6767 Fx: 352-243-2255
The Palms Plaza, 7780 Lake Underhill Rd, Ste 110, Orlando, FL 3288 Ph: 407-608-7871 Fx: 407-608-7872