Arizona Asthma & Allergy INSTITUTE
www.azsneeze.com

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CONSENT FOR MEDICAL TREATMENT / RELEASE OF INFORMATION

Effective Date:_____ Termination Date: _____

Patient Name:_____ Date of Birth:_____

Parent or Legal Guardian Name:_____

Designee #1_____ Designee#2_____

(Must be 16 years or older) (Must be 16 years or older)

Address:_____ Address:_____

City, State, Zip code:_____ City, State, Zip code:_____

Telephone: H:_____ W:_____ Telephone: H:_____ W:_____

CONSENT TO AUTHORIZE MEDICAL CARE RELATING TO IMMUNOTHERAPY

_____Parents or Guardians consent that Custodian authorize on their behalf any first aid or medical care which Custodian in his discretion deems necessary for the health or treatment of any illness or injury of Minor Child occurring during this temporary custody.

_____I hereby give my permission for my child who is 16 years of age or older to receive his/her allergy injections without myself being present.

CONSENT FOR TREATMENT

_____I hereby give my consent for the above named person(s) to act as medical guardian for an office appointment and treatment of my minor child.

CONSENT FOR RELEASE OF INFORMATION

_____I hereby give my consent for the release of medical information to the above named person(s) regarding my minor child or myself.

FINANCIAL RESPONSIBILITY

Parents or Guardians will be financially responsible for any medical treatment rendered to Minor Child.

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN/PARENT DATE

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN/PARENT DATE

_____ _____

SIGNATURE OF TEMPORARY CUSTODIAN DATE