

CONSENT TO DISCUSS MEDICAL CARE

Patient Name: (please print): _____
(First, M.I., Last Name)

Date of Birth: _____ Patient's Account No: _____

I authorize Northwest Asthma & Allergy Center PS (NAAC) to discuss my medical information with the following individuals I have listed below. (Please print all names listed below)

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

I give my permission for NAAC to leave medical information at my home telephone number
 Yes No

(Signature of Patient, Parent or Legal Guardian) (Date signed)

(Printed name of signature above)

CONSENT FOR TREATMENT OF A MINOR

Date: _____

I, _____, the parent or legal guardian of my
(Please print)

child, _____,
(Patient's name, please print) (Date of birth)

authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required and I waive my right of prior informed consent to such treatment. **This authorization shall remain effective unless revoked in writing by me.**

(Signature of Parent/Guardian) (Date signed)

NOTE: For your child's safety, Northwest Asthma and Allergy Center requires all children under the age of 12 to be accompanied by an adult (18 years or older) for the duration of their visit when receiving allergy shots or being seen by the physician.