Allergy & Asthma Associates of Allen

Patient Name: _____

Date of Birth: _____

Confidential Voicemail Authorization

- Occasionally, it may become necessary to contact our patient(s) by telephone. In the event you are not available by phone, we will leave detailed voicemail messages regarding you/your child's treatment. By providing your telephone number(s), you hereby grant Allergy & Asthma Associates of Allen permission to leave detailed voicemail messages regarding you/your child's treatment.

My Cell Phone: _____ My Home Phone: _____

○ I do not wish to receive voicemail messages regarding my/my child's treatment.

- I give permission for Allergy & Asthma Associates to provide my personal healthcare information to:

Name: _____ (Relationship to Patient): _____

Name: _____ (Relationship to Patient): _____

E-Mail Messaging Authorization

E-Mail: _____

○ I do not wish to receive emails from Allergy & Asthma Associates of Allen.

Mailing Address

_____
(Street Address)

_____
(City, State, Zip)

_____	_____	_____
Patient's Printed Name	*Patient's Signature*	*Date*
_____	_____	_____
**Legal Representative's Printed Name*	*Legal Representative's Signature*	*Date*

_____
**If representative, Specify relationship to patient*