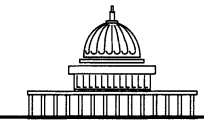

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

Permission to be Involved in Patient Care

By signing this form, I authorize Capital Allergy to exchange any necessary information with the person(s) named below. This may include treatment, diagnoses, test results, demographic and billing information. I also authorize the person(s) named below to make medical decisions on my behalf.

Patient Name _____

DOB _____

Authorized Person Name_____

Relationship_____

Phone Number_____

Authorized Person Name_____

Relationship_____

Phone Number_____

Authorized Person Name_____

Relationship_____

Phone Number_____

Patient/ Guardian Signature _____

Date _____