# WAIVER FOR TREATMENT

Patient Name: _____ Date of Birth: _____

I understand by signing this authorization, I confirm I am the parent, guardian, or responsible legal party and I am able to execute this document on behalf of the charge named herein. I understand any change to this authorization must be in writing. In the event of revocation, the parent or legal guardian executing revocation is required to notify the other parent or applicable legal guardian(s). Midwest Allergy is not responsible to execute notification of revocation.

I understand that valid insurance must be provided in advance or at time of service. I am responsible for completing applicable patient forms prior to appointments.

I authorize the following individual(s) to accompany my minor child, incapacitated adult, or principal ("charge") to appointments and to obtain medical services at Midwest Allergy and Asthma Clinic, P.C.

Authorized individual: _____ Relation to patient: _____

Authorized individual: _____ Relation to patient: _____

Authorized individual: _____ Relation to patient: _____

_____ _____
Name Relation to patient

_____ _____
Signature Date

I authorize my charge to obtain medical services without my presence and without any additional adult supervision at Midwest Allergy and Asthma Clinic, P.C. (*Please note that patients must be 18 years of age for physician appointments and at least 16 years of age to receive immunotherapy injections. Exceptions may be made on a per case basis*).

_____ _____
Name Relation to patient

_____ _____
Signature Date

Verbal Authorization

The above statement has been read to the parent, legal guardian, or responsible legal party of the charge and agreement of the statement by the parent or legal guardian has been witnessed by:

_____ _____
Witness Signature Date

_____ _____
Witness Signature Date