AUTHORIZATION TO PREPARE
ALLERGEN EXTRACT

I hereby authorize Allergy & ENT Associates to prepare allergen extract for allergy immunotherapy for me or my dependents.

I understand the office will work with me in filing charges with my insurance carrier. I will be responsible for payment of charges not covered by my insurance. (For REFILLS the charge for the extract does not always coincide with the preparation dependent on the frequency of injections.)

______________________________	______________________________
Patient Name (Please Print)	**Date of Last Office Visit with MD**
______________________________	______________________________
Signature **Date**	**Date of Birth**
______________________________	______________________________
Daytime Telephone #	**Allergy & ENT Associates MD**
______________________________	______________________________
Address	**Insurance Company**
______________________________	______________________________
City/St./Zip	**Witness**

<u>FOR REFILLS ONLY</u>: Please complete the immunotherapy Re-evaluation Questionnaire on the back of this form.

Mail or Fax________________________________the following completed forms to your physician's office if you receive your injections at a location other than an our office:

1. **Antigen Injection Schedule/Record**
2. **Authorization to Prepare Allergen Extract**
3. **Immunotherapy Re-Evaluation Form**

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