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

FOR REFILLS ONLY:

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 our office:

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