ALLERGY AND ASTHMA CONSULTANTS, P.C.

Paul S. Rabinowitz, M.D. Mark D. Livezey, M.D., Ph.D. Glen L. Nadel, M.D.

ALLERGY IMMUNOTHERAPY AUTHORIZATION

Account Number: ______________________________

Name: ____

I wish to begin a program of allergy immunotherapy, the details of which have been explained to me.

My signature below indicates my permission for Allergy and Asthma Consultants, P.C. to prepare allergy serum for me.

______________________________ ______________

Signature Date

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Fax: (770) 740-9306

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