Allergy & Asthma Center
of Southern Oregon, PC
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Appointments 1-541-858-1003   Fax (541) 857-4499

Re-Mix Authorization Form

I ______________________________ __________________________ _________________________

(Patient's name)   (Parent/Legal guardian's name)   (Patient's Date of Birth)

wish to continue with my/my child's allergy immunotherapy program and hereby authorize Allergy & Asthma Center to re-mix my/my child's allergy extract(s). I understand that I need to provide Allergy & Asthma Center with a current copy of my/my child's insurance card at the time I sign this authorization. If I do not have the insurance card in my possession at the time of signing, I understand that I will be responsible for payment of the extract(s) if the insurance information on file with Allergy & Asthma Center is incorrect or invalid.

I have read, understand, and agree to the above statement:

____   ____________________
(Patient's signature/Legal guardian's signature)   (Date)

____   ____________________
(Shot nurse's/MA's signature as witness)   (Date)

____   ____________________
Signature of MD overseeing IT (Dr. Kerwin/Dr Parks/Dr. Israelsen)   (Date)

Copy of insurance card below:

Office where shots are given   MED   GP   KF   ASH

OUTSIDE OFFICE ____