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CONSENT TO ALLERGY EVALUATION AND TESTING

1. I authorize the performance of allergy evaluation and testing upon:

_____ (patient's name) DOB: _____
to begin on _____ (today's date) at Mile High Family Medicine
under the direction of _____ (name of your doctor).

2. I consent to:

a. The testing procedures.

b. Such procedures and treatment in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the testing procedures.

c. The administration of such medications as may be considered necessary or advisable by the doctor or associates or assistants responsible for this service.

d. The admittance of observers to the room for the purpose of advancing medical education.

3. I have been explained the nature of all the testing procedures, the risks involved with this testing, and the possibility of complications such as: localized swelling, irritation, and itching at the testing sites. The patient may also experience an increase in his/her allergic symptoms, generalized (whole body) hives and swelling, difficulty breathing, anaphylactic shock, and possible death. No guarantee or assurance has been given by anyone as to the results that may be obtained.

4. I certify that I have read and fully understand the above consent to allergy testing, that the explanations therein referred to were made, that all blanks or statements requiring insertion or completion was filled in and that inapplicable paragraphs, if any, were stricken before signed.

5. I acknowledge that my benefits were a quote only, and MHFM is not responsible for my insurance company's misquotation of benefits for testing or treatment, if this occurs.

Signature of Patient or Responsible Party _____

The foregoing consent was read, discussed, and signed in my presence, and in my opinion the person so signing did so freely with full knowledge and understanding.

Signature of Witness _____ Date _____