Alvernon Allergy & Asthma, P.C.

www.alvernonallergy.com

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Adult & Pediatric Allergy, Asthma & Immunology

Authorization to Release Information

I, _____ authorize Alvernon
Patient Name

Allergy & Asthma, P.C. to release information about my healthcare to the following family member(s) or friend(s) if requested:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ I Do Not want information shared with anyone.

_____ _____
Signature **Relationship to patient**

_____
Date Signed

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