Allergy and Asthma Associates, P.C.

PATIENT REQUEST FORM

Patient Name: _____ Date of Birth: _____/_____/_____

Who to call if there's any question about the form:_____ Phone: _____

Self-Carry Epinephrine/Inhaler? **YES/NO** Self-Administer Epinephrine/Inhaler?

YES/NO Has the patient had any anaphylaxis? **YES/NO** **Weight**: _____lbs

TYPE OF REQUEST:

◯School/Camp/Disability Form (provide form)

◯Letter From Provider (please explain) _____

ONCE REQUEST IS PROCESSED, PLEASE NOTIFY ME BY:

◯Email: _____◯Text:_____

ONCE NOTIFIED, I WOULD LIKE MY REQUEST: (choose one)

◯ Emailed to: _____◯

Faxed to: _____◯

Left in office for pick up (select one): ◯STERLING OFFICE ◯MCLEAN OFFICE

I UNDERSTAND I AM GIVING MY CONSENT FOR CONFIDENTIAL INFORMATION TO BE DISCLOSED.
I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING TO THE PERSON IN POSSESSION OF MY RECORDS.

PLEASE SEE RECEPTION FOR ANY FEES ASSOCIATED WITH YOUR REQUEST. PAYMENT MUST BE MADE PRIOR TO FORM/LETTER PROCESSING, AND ACCOUNTS MUST BE CURRENT. SOME REQUESTS MAY REQUIRE AN OFFICE VISIT.

_____ _____/_____/_____ **SIGNATURE DATE**

****OFFICE USE ONLY****

REQUEST FORM RECEIVED ON: _____/_____/_____ **FORMS COMPLETED BY:** _____ **# OF FORMS COMPLETED/TO BE BILLED:** _____ **PAYMENT TYPE**: : □ COF □ CASH □ CHECK □ CC