Allergy & Asthma Center
of Southern Oregon, PC
Edward M. Kerwin, MD Kevin W. Parks, MD
Jennifer K. Milligan, PA-C Jaleh Ostovar, FNP-C
Appointments 1-888-558-1003 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) **(Date)**

Copy of insurance card below: