Mt. Lebanon Allergy Associates
Mina Patel M.D.
Allergy/Immunology

To: Mt. Lebanon Allergy Associates
Re: Authorization to treat

Patient: _____ DOB: _____

I, _____ (parent) give my permission for

_____ to bring _____

(patient's name) for treatment without a parent in attendance.

You may be able to reach me at _____(phone#) during treatment for any reason.

_____ Date _____
Parent Signature

_____
Parent Name (print)

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