Allergy & Asthma Center of East Orlando

Boyce A. Hornberger, M.D, FAAAAI
Diplomate American Board of Allergy and Immunology

To: Allergy & Asthma Center of East Orlando
Re: Authorization to Treat

Patient: _____ DOB: _____

I, _____ (parent) give my permission for

_____ to bring _____

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

_____ Date _____
Parent's Signature

_____
Parent's Name (print)

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