Silver Falls Dermatology
ALLERGY VEINS AESTHETICS

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IMMUNOTHERAPY VIAL RELEASE FORM

I, _____, agree to have my allergen immunotherapy vials sent to the clinic of my choice. Please send my allergen vials to:

_____

_____

I understand and acknowledge that any further allergy or asthma treatment and care will need to be with another allergist of my choice.

(Signature of Patient) (Date of Birth) (Date)