the allergy station
Travis A Miller MD

phone/fax: (916) 238.6238
1478 Eureka Road Suite 290
Roseville CA 95661
theallergystation.com

RELEASE OF ANTIGEN CONSENT FORM

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________

I request that my own or my child's allergy extract prepared by:

____

Be administered under the supervision of Travis A. Miller, MD

______________________________ ______________________________

Signature of Patient Date:

By signing this form, the supervising physician acknowledges his or her medical responsibilities. These responsibilities include reading the Allergy Immunotherapy Instructions before beginning this therapy, doing patient assessment before giving injections and treatment of untoward or local and or systemic allergic reactions.

Patients will receive their allergy injections in our office and while the responsible physician or delegate is on the premises.

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Name of Supervising Physician: (PRINT)

______________________________ ______________________________

Signature of Supervising Physician Date:

NAME OF ALLERGY FACILITY: The Allergy Station
FACILITY ADDRESS: 1478 Eureka Road, Suite 290, Roseville, CA 95661
FACILITY PHONE NUMBER: (916) 238.6238