**ALLERGY & ASTHMA, P.C. LAWRENCE I. PASIK, M.D.**

# 5775 W. MAPLE ROAD **NENA S. KASMIKHA, M.D.**

# WEST BLOOMFIELD, MI 48322 **CATHRYN LURIA, M.D.**

# www.allergyasthmapc.com **GAGANDEEP CHEEMA, M.D.**

Telephone: (248) 626-5315 Fax: (248) 626-2248

**PATIENT CONSENT TO DISCLOSE MEDICAL INFORMATION**

Date: Patient Name:

I give permission to Allergy & Asthma, P.C. to release my medical care and treatment, unless otherwise prohibited, to

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(Name)

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(Relationship)

I understand that I have the right to terminate this agreement at anytime, by notifying Allergy & Asthma, P.C. in writing.

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(Patient’s signature) (Date)

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(Witness’s signature) (Date)