WELCH PASTEUR ALLERGY MEDICAL GROUP, INC
A. CARMEN CHOY, M.D., HAILEN MAK, M.D
211 QUARRY ROAD, SUITE 106
MAIL CODE 5996
PALO ALTO, CA 94304
PH: 650-322-3847 FAX: 650-322-3249

DATE:_____

PATIENT NAME:_____

TO:_____

_____

_____

YOU ARE HEREBY AUTHORIZED TO GIVE DR CHOY/ DR MAK ANY AND ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHEN UNDER OBSERVATION OR TREATMENT BY YOU, INCLUDING

___HISTORY ___PHYSICAL FINDINGS ___DIAGNOSIS

___LABORATORY DATA ___SKIN TEST RESULTS ___COMPOSITION OF ANTIGENS

SIGNATURE:_____ WITNESS:_____
ADDRESS:_____

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