CORNERSTONE ASTHMA & ALLERGY ASSOCIATES, LLC
Eric W. Bantz, MD and John Y. Kim, MD
Diplomates, American Board of Allergy and Immunology
103 Old Marlton Pike Suite 211
Medford, New Jersey 08055
TEL (609) 953-7500 // FAX (609) 953-9085

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____Date of Birth: _____

I give permission for Cornerstone Asthma & Allergy Associates to discuss medical information for the above-named patient, including examinations and test results, with the following friends and/or family members. NOTE: If left blank, information will only be given directly to the patient (or parent/guardian if under age 18 years).

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

This authorization will remain in effect at Cornerstone Asthma & Allergy Associates until it is either revoked or changed.

This document is authorized and signed by ___ self ___ parent ___ guardian (check one)

_____ _____
Signature Today's Date

_____
Printed Name