Dilley Allergy & Asthma Specialists, LLP
7835 IH 10 West
San Antonio, Texas 78230
210-614-4405

Disclosure and Consent for Allergy/Asthma Testing, Evaluation and Treatment

❑ I, _____, as the patient, voluntarily request Dennis E. Dilley, MD or Gary Dunham, PA-C as my physician/caregiver to treat the condition and hereby release them and any other participation health care providers, from any and all liability for any adverse effects that may result from the following procedures required to diagnosis and treat my condition.

❑ I, _____, as parent or guardian of a minor under 18 years of age, voluntarily request Dennis E. Dilley MD,/ Christopher Calabria MD/ Phillip McAllister, PA-C my physician/caregiver to treat the condition of _____ DOB _____, hereby release them and any other participation health care providers, from any and all liability for any adverse effects that may result from the following procedures required to diagnosis and treat his/her condition. I further agree that in the absence of my presence, the above physicians and/or medical staff may provide routine or emergency procedures as required for patient care, i.e. allergy injections, treatment of allergic reaction, discussion of treatment, etc.

- Allergy Testing
- Pulmonary function testing
- Immunotherapy (Allergy Injections) /R.U.S.H Immunotherapy
- Other diagnostic procedure to include Lab, X-rays, etc.

❑ I understand that my physician may discover other or different conditions that require additional or different procedures than those planned.

❑ I understand that medicine is not an exact science and acknowledge that no guarantee or assurances have been made to me as to result or cure.

❑ Just as there may be risks and hazards in the continuing of my present condition without treatment, there are also risks and hazards related to the performance of the medical or diagnostic procedures indicated.

❑ I realize that thought rare, with medical diagnostic procedures there is the potential for infection, allergic reactions and even death.

❑ I have been given an opportunity to ask questions about my condition, the potential treatments, the risks of non-treatment, the procedures to be used and the risks and hazards involved.

❑ I believe that I have sufficient information to give this informed consent.

❑ I certify this form has been fully explained to me, that I have read it of have had it read to me, and that I understand its consent.

_____ _____ _____
Signature of Patient or Guardian Relationship Date

_____ _____ _____
Printed Name Printed Name of Patient Patients D.O.B.