Consent for Allergy Testing

Date: _____

Patient's Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Dear [Healthcare Provider's Name],

I, the undersigned, hereby give my consent for allergy testing procedures to be performed on me.

I understand that the purpose of the allergy test is to determine if I have any allergic reactions to specific substances. The test may involve skin pricks or intradermal injections, and I acknowledge that there may be risks, including local reactions or allergic responses.

I have been informed about the procedure, the associated risks, benefits, and alternatives. All my questions have been answered to my satisfaction.

By signing below, I give my consent for the allergy testing to be conducted as prescribed by my healthcare provider.

Signature: _____

Relationship to Patient (if applicable): _____

Date: _____

Contact Information

If you have any questions or concerns, please feel free to contact me at:

Phone: _____

Email: _____

Thank you for your attention to this matter.

Sincerely,

_____

[Patient's Name]