ALLERGY
AND ASTHMA ASSOCIATES
PEDIATRIC & ADULT ALLERGY, CLINICAL IMMUNOLOGY
Salmon S Goldberg, MD • David S Chudwin, MD • Kathy R Sonenthal, MD • Irma M Oliff, M.D. • JK Lawson, MD

Consent to Leave a Medical Message on phone/email

Patient Name _____ DOB _____

We will call you with your Lab, X-Ray or CT scan results, usually within one week from the date you had your test. If you have not heard from us within 10 days, please call our office.

To protect your privacy, please confirm who we can talk to regarding your results:

___ Patient only

___ Spouse (print spouse's name) _____

___ Parent or Guardian (print name) _____

(circle your answer)

May we leave normal results on your answering machine or voice mail: YES NO

Does this authorization include discussion of your office visits and medical history YES NO

Home phone # _____

Cell phone # _____

Work phone # _____

Email: _____

X_____ Date _____

Signature of ____Patient _____Parent _____Guardian

500 Skokie Blvd, Ste 140
Northbrook, IL 60062
(847) 272-4296

150 W. Half Day Rd, Ste 200
Buffalo Grove, IL 60089
(847) 793-0777

475 Brown Blvd, Ste 104
Bourbonnais, IL 60914
(815) 933-5092

300 Memorial Dr, Ste 250
Crystal Lake, IL 60014
(815) 455-7289