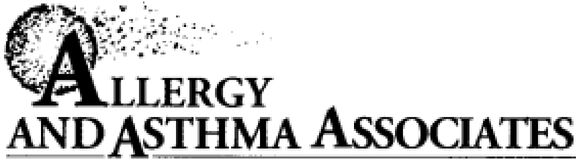

PEDIATRIC & ADULT ALLERGY, CLINICAL IMMUNOLOGY

Salmon S. Goldberg, M.D. • David S. Chudwin, M.D. • Kathy R. Sonenthal, M.D. • Irma Oliff, M.D. • John K. Lawson, M.D.

Consent to Leave a Medical Phone/E-mail Message

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 withi 10 days, please call our office.

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

___ Patient only
___ Spouse (please print spouse name)____
___ Parent/guardian/relative (please print name)__________________________________

May we leave normal results on your answering machine or voice mail: YES NO (circle one)

Does this authorization include discussion of your office visits and medical history: YES NO (circle one)

Please list your contact numbers:

___-___-____ belongs to _____________________

___-___-____ belongs to _____________________

___-___-____ belongs to _____________________

E-mail____

X____ Date:_______________
Signature of ___Patient ___Parent ___Guardian

☐ 500 Skokie Blvd, Ste 140
Northbrook, IL 60062-2811
(847) 272-4296

☐ 150 W. Half Day Rd, Ste 200
Buffalo Grove, IL 60089-1782
(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