RELEASE OF ALLERGY IMMUNOTHERAPY SUPPLY

Allergy Partners, PLLC has informed me that the Allergy Partners of Rowan-Salisbury office located at 420 Mocksville Ave, Salisbury, NC (Phone 704-431-4253, Fax 704-431-4325) will close on **April 6th, 2025.** I receive allergy immunotherapy at this office, and I acknowledge that in order to continue allergy treatment and allergy shots, I must coordinate my allergy treatment with another allergist and my allergy shots with either another allergist or primary care physician. To transfer my allergy immunotherapy supply (extract) to the physician who will provide my future allergy shots, I am providing accurate information and consent below:

Initial here: _____

I authorize Allergy Partners to send my extract to the following provider and address:

____
Provider Name

____
Street Address

______________________________ __________________ ____________
City State Zip

_________________________ _________________________
Phone Fax

I understand that I must make arrangements for my extract to be shipped to a medical facility by April 6th, 2025. Completed forms submitted after April 6th, 2025, will be faxed to 828-277-2499 and may result in a delay in shipping.

I understand that Allergy Partners, PLLC and the physicians and staff of this office cannot be held responsible for any adverse reactions which may occur if I do not follow the guidelines above.

I have read and fully understand the information on this Release of Allergy Immunotherapy Supply form. I have been provided with the opportunity to ask questions about this process.

______________________________ __________________________
Patient's Name (please print) Date of Birth

______________________________ __________________________
Patient or Parent/Guardian Signature Date