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ALLERGY TESTING & TREATMENT CONSENT FORM

I authorize Dr. Hughes and such assistants as he may designate to perform upon _____ the following diagnostic procedure: Quin or Intradermal testing for detection of possible allergies.

I further consent to the performance of such other or additional procedures different from that now contemplated, whether or not arising from presently foreseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the procedure. I have been made aware of certain risks and complications that are associated with this allergic testing procedure.

I have also been informed there are other risks associated with skin testing and treatment. These include, but are not limited to, hypotensive episodes, aggravation of allergic symptoms (runny nose, itchy eyes, hives), and in rare cases anaphylactic reaction. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

Witness

Patient or Parent/Guardian

Date

Relationship