

ADVANCED ALLERGY RELIEF of HAWAII

WAIVER AND RELEASE

I _____ (the "Undersigned"), hereby consent to treatment by Advanced Allergy Relief of Hawaii (AARofHI) also known as Absolute Allergy Relief

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results. AARofHI also cannot guarantee that new allergies will not develop in the future. While AARofHI can treat most forms of allergies, some cases do not respond to the treatment.

I also understand that the only known risk factor with allergy desensitization, (including medical immunotherapy) is the possibility of increased sensitivity. I assume all responsibility for unpredictable immune reactions which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

No, I do not have any life threatening allergies.

Yes, I have the following allergies that may cause anaphylaxis:

I agree to pay the clinic the standard fee for any and all treatments administered unless otherwise stated by the Clinic staff.

IN WITNESS THEREOF, the undersigned executed the Agreement

the _____ day of _____ 2008

Signature of Undersigned

Signature of Parent or Legal Guardian

Signature of Witness