



**WILKINSON SNOWDEN OTOLARYNGOLOGY CONSULTANTS, P.A.**

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**AUTHORIZATION TO RELEASE INFORMATION**

**(TO FAMILY/ FRIENDS)**

I, \_\_\_\_\_ authorize my information to be  
(Patient Name)  
given to \_\_\_\_\_  
(Family / Friends)

regarding the **initialed** items below. I understand that by signing this form **only** the person(s) designated above is/are allowed to obtain my information and they are **only** allowed to obtain information regarding the items that I have designated below. By **initialing** beside **All Information** I understand that the person listed above will have availability to all of my medical and personal information that the office of Wilkinson Snowden Otolaryngology Consultants, P A has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and / or change this authorization.

- \_\_\_\_\_ APPOINTMENT DATES/ TIMES
- \_\_\_\_\_ TEST RESULTS
- \_\_\_\_\_ OFFICE NOTES
- \_\_\_\_\_ SURGERY INFORMATION
- \_\_\_\_\_ INSURANCE INFORMATION
- \_\_\_\_\_ ALL INFORMATION
- \_\_\_\_\_ OTHER \_\_\_\_\_

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date