SOUTHWEST EAR, NOSE & THROAT
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, do hereby authorize Southwest Ear, Nose & Throat, PLLC to release my medical information to the following persons or offices.

1. _____ Relation _____
2. _____ Relation _____
3. _____ Relation _____
4. _____ Relation _____
5. _____ Relation _____

_____ _____
Name (print) **Name (sign)**

____/____/_____
Date

_____
Witness

____/____/_____
Date