

Wilmington Ear Nose & Throat  
Authorization to Release Medical Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Please list any person or organization you authorize to have access to your medical information. (Family member(s), other physicians, etc.)

Because of the HIPPA Privacy Act we cannot divulge any information unless you designate that person to receive such information. WENTA can submit any information needed to your insurance company for the purpose of payment.

Medical information may include:

- Physician's notes
- Lab reports
- Diagnostic studies
- Pathology reports

Person(s) that I authorize access to my medical information are:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_