Ear, Nose, & Throat Consultants of North Mississippi
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MEDICAL WAIVER

This is to authorize my physician, ____________________________, to speak with
(Name of physician)

______________________________ who is my ______________________________, and
(Name of contact person) (Relationship)

discuss with them the medical treatment I have been receiving from my physician and his clinic and any other matters related to that medical treatment.

In addition, the doctor, nurse or office staff may need to leave a message on your voicemail when trying to contact you or your contact person listed above.

This authorization shall remain in effect until such time as it is withdrawn by me in writing, regardless of the date signed.

______________________ ______________________________________
Date Signature

I give my permission to ENT Consultants to fax a medical excuse at my request to **school** or **place of employment**.

_________________________ ______________________________________
Date Signature

____
Witness