Daniel L. Wohl, M.D.
Pediatric Otolaryngology Associates

To Whom It May Concern:

I, _____, hereby give permission for Daniel L Wohl, MD, or any member of his staff, to speak with and/or discuss medical decisions with _____ and/or _____, who is/are my _____, on behalf of _____(patient).

This permission is granted starting on

- ☐ ___/___/201_ until ___/___/201_,
- ☐ ___/___/201_ and can continue indefinitely, until I say otherwise, up to 12 months.

_____
Name

_____
Relationship to Patient

_____
Signature

_____
Date

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