WILSON MEDICAL ASSOCIATES, P.A.

P.O. BOX 7015
200 GLENDALE DR. W
WILSON, NC 27895

GUARANTOR #__________________ MR# ____________________

AS OF THIS DATE, _______________, I, _______________________________
GIVE MY PERMISSION, AND HEREBY AUTHORIZE _____________________
COMPLETE ACCESS TO ANY AND ALL FINANCIAL/MEDICAL INFORMATION REGARDING MY ACCOUNT/CARE.

___________________________________ _______________
PATIENT'S SIGNATURE DATE

___________________________________ _______________
WITNESS DATE