THE HEART CENTER of NORTH TEXAS

Authorization for Release of Medical-Related Information

1. I authorize Dr. _____ to disclose complete information to [name of insurance company] concerning his medical findings and treatment of the undersigned.

2. Further, I authorize him to testify without limitation, as to all medical findings and the treatment administered to the undersigned, in any legal action, suit, or proceedings to which I am, or may become, a party; and I waive on behalf of myself and any persons who may have an interest in the matter all provisions of law relating to the disclosure of confidential medical information.

Signed,

_____	_____
Patient	Witness
_____	_____
Date	Place