THE HEART CENTER of NORTH TEXAS

Signature on File Form

I authorize any holder of medical or other information about me to release to [the Social Security Administration and Health Care Financing Administration or its intermediaries, carriers, and agents or name of insurance company], any information needed to determine the benefits for this or a related claim.

Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of Benefits apply.

______________________________ ______________________________

Signature Date