The Heartbeat Clinic

Amer Suleman M.D

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize: The Heartbeat Clinic – Dr. Amer Suleman to release healthcare information of the patient named above to:

Name: _____

Address: _____

Phone: _____ Fax: _____

The request and authorization applies to:

□ Healthcare information relating to the following treatments, conditions, and/or dates:

_____

_____

□ All healthcare information

□ Other: _____

□ Yes □ No - I authorize the release of my records to the person(s) listed above.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

PLEASE FAX FORM TO US AT 214-504-9940