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: ________________________ to release healthcare information of the patient named above to:

Name: The Heartbeat Clinic – Dr. Amer Suleman

Address: 4541 Medical Center Dr. #800 McKinney, TX 75069

Phone: (214) 504-9942 Fax: (214) 504-9940

The request and authorization applies to:

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

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□ 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