The Heartbeat Clinic

Amer Suleman M.D

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize to release healthcare information of the patient named above from:

Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

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

Email: info@thbc.us

The request and authorization applies to:

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

_____

_____

□ All healthcare information

□ Date ranges (if applicable): _____

□ 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