Authorization for Discussion of Medical Information

I , the undersigned hereby authorize Drs. Mark M. Applefeld; Monica Aggarwal, M.D. and Amish C. Sura, M.D. of the Mercy Heart Center at Mercy Medical Center to discuss any and all aspects of my medical care and treatment with the following designated individuals:

Name	**Relationship**

I understand that it is my responsibility to inform the staff of the Heart Center at Mercy if additions or deletions need to be made to this authorization form. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Heart Center at Mercy. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _______________.

If I fail to specify an expiration date, event or condition, this authorization will expire in one (1) year.

__________________ __________________ ____________

Last First Middle initial

_______________________________ ______________

Signature of Patient or Legal Representative Date

If signed by Legal Representative, Relationship to Patient | Signature of Witness

Mercy Heart Center

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