I hereby authorize the release of any records, information, and data pertaining to me, my medical history, or services rendered to me by the hospital/physician to the Heart Failure Clinic.

I also authorize the heart failure clinic to release the results of tests, treatment plan, and recommendations for my care to my personal physician.

I understand that these records, information, or data will be kept confidential in accordance with the law and medical regulations.

Patient signature: ______________________________

Date: ______________________________