Advanced Heart Care,LLC

Patient Authorization for Disclosure of Protected Health Information.

By signing, I authorize Omar Almousalli, MD to disclose protected health information (PHI) about me to the following individuals listed.

1.) _____ _____
Name Relationship to Patient

2.)_____ _____
Name Relationship to Patient

3.)_____ _____
Name Relationship to Patient

Signed by:_____ Date: _____

Print Patient Name:_____