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Dear Patient,

In the event of an emergency, with whom may we discuss your medical condition/treatment and/or medical information?

1. _____ PH# _____
2. _____ PH# _____
3. _____ PH # _____
4. _____ PH # _____
5. _____ PH# _____

Your signature on this form indicates that Texas Institute of Cardiology, P.A. has your written permission to disclose your information to the listed individuals.

You may delete or add names to this list at anytime and the information provided should be updated annually.

Thank you,
 Texas Institute of Cardiology, P.A.

Printed Patient Name: _____ Date: _____

Patient Signature: _____