

# Big Apple Cardiology

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## Authorization to Communicate Medical Information

### Authorized Individuals

I authorize Allen Weiss Physician NY, P.L.L.C. d/b/a Big Apple Cardiology to discuss my medical information with the following individuals:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that this authorization allows these individuals to receive medical information regarding my care, including test results and treatment plans.

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Electronic Patient Signature (captured digitally)

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Timestamp Recorded Automatically