WHOM CAN WE DISCUSS YOUR MEDICAL INFORMATION WITH?

Surgeon Name:_____

Surgery Department:_____Cardiothoracic Surgery_____

Patient Name:_____

PLEASE DESIGNATE FAMILY AND FRIENDS WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

Designated party:_____Relation to Patient:_____

Designated party:_____Relation to Patient:_____

Designated party:_____Relation to Patient:_____

Designated party:_____Relation to Patient:_____

1. **I understand that I can revoke this authorization at any time. Initial_____**
2. **I understand that my treatment cannot be conditioned on whether I sign this authorization. Initial_____**

_____ _____

Signature of patient or patient's representative Date