The SWICFT Institute
625 9th Street North
Suite 201
Naples, FL 34102
239.261.2000 Phone
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James V. Talano, MD, MM, FACC
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Jennifer Mazorra, ARNP
Jordan Beaverson, PA-C

Authorization to Disclose Information

I, _____ **DOB:** _____, authorize:

SWICFT Institute, Dr. _____
625 9th Street N, Suite 201
Naples, Fl 34102

to RELEASE my medical information to:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I request, as per my right through HIPPAA regulations, that the above named office be granted to release the following information on my behalf:

- **Information from my visit with the physician or physician's midlevel**
- **Results of testing**
- **Any information regarding my cardiovascular health**
- **Appointments**

Patient Signature: _____ Date: _____

Witness Signature: _____ Title: _____