



The SWICFT Institute
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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 HIPAA 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: _____

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