Heart and Vascular Care

Charanjit S. Khurana, MD, MRCP, FACC, FSCAI
Asst. Clinical Prof. of Med. GWU

If you would like to give permission for anyone else other than yourself to have access or discuss your medical treatment (i.e. spouse, children, siblings) please advise us by filling out this form.

I, ____, authorize the following person(s) to discuss and/ or receive information related to my medical care:

Name	Relationship to Patient

Signature: ____ Date: ________________________

1715 N. George Mason Drive, Suite 107, Arlington, VA 22205 ❋ Phone 703-527-1400 ❋ Fax 703-525-0043
www.HeartandVascularcare.com