LIBERTY
HEART CENTER
J.BARTON WILLIAMS, MD, P.A.

MEDICAL AUTHORIZATION FORM

Date: _____

I _____, **hereby authorize Liberty Heart Center to discuss any and all medical test/results including my plan of care with** _____

Address: _____

_____

Phone Number: _____

Relationship: _____

Name/Address/Phone/Relationship: _____

Name/Address/Phone/Relationship: _____

Name/Address/Phone/Relationship: _____

Name/Address/Phone/Relationship: _____

Name/Address/Phone/Relationship: _____

Signature of Patient/Patient's Representative: _____

Witness: _____

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