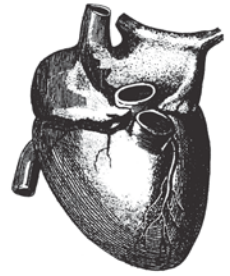


NORTHERN VIRGINIA CARDIOLOGY ASSOCIATES



I hereby authorize _____
(telephone # _____/ fax # _____) to release my health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to re-disclosure and no longer protected by privacy laws. You may disclose this health information to:

Northern Virginia Cardiology Associates
8505 Arlington Boulevard, Suite# 200
Fairfax, Virginia 22031
(703) 698-8525 (telephone) (703) 849-1918 (fax)

NORTHERN
VIRGINIA
CARDIOLOGY
ASSOCIATES
PROFESSIONAL CORPORATION

You may disclose the following health information (check all that apply):

- _____ Entire record.
- _____ Health information related to the following treatment or condition:

- _____ Health information for the following date(s): _____
- _____ Other (specify): _____



8505 Arlington Boulevard
Suite 200
Fairfax, Virginia 22031
(703) 698-8525
Fax (703) 849-1918

Patient Rights:

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that I may see and request a copy of this form after I sign it. I understand that this authorization can be revoked by notifying _____ in

(Name of doctor/practice/group)

writing, but if I do, it will not affect any actions already taken based upon this authorization.

Patient Name: _____

SSN: _____ Date of Birth: _____

Address: _____

Telephone: _____ Date of Request: _____

This authorization will expire on the following date, event or condition:

X _____

Signature of patient/guardian

Relationship to patient

Date faxed/mailed: _____ Date received: _____

- CARL P. BON TEMPO, M.D., F.A.C.C.
- HARVEY S. SHERBER, M.D., F.A.C.C.
- JACK D. HORTON, M.D., F.A.C.C.
- BRYAN D. RAYBUCK, M.D., F.A.C.C.
- CHRISTINE D. BUSSEY, M.D., F.A.C.C.
- TODD G. MATROS, M.D., F.A.C.C.
- TODD C. PULERWITZ, M.D., F.A.C.C.
- TINA SLOTTOW, M.D.