

AUTHORIAZATION TO RELEASE/ FINANCIAL AGREEMENT

I hereby authorize THORACIC CARDIOVASCULAR ASSOCIATES to release to my insurance company and information acquired in the course of my examination and treatment that may be necessary to determine the benefits payable for related services. I also authorize payment of benefits directly to THORACIC CARDIOVASCULAR ASSOCIATES, and I understand that I am financially responsible for any charges not covered by this authorization.

Patient Signature _____ Date: _____