

Terre Haute Heart Lung Vascular Associates

Eduardo Esper, M.D., FACS, FCCP

As a patient of Terre Haute Heart Lung Vascular Associates, I understand that there may be occasions where the office may need to contact me regarding appointments, scheduling of tests, test results, medications, etc. in such an event, if I am unavailable, I authorize Terre Haute Heart Lung Vascular Associates and staff to discuss my medical records (including test results and plan of care) with the individuals listed below. This authorization also includes the leaving of voice mail messages on my home, work and/or cell phone. I understand that I may revoke this authorization at anytime by notifying the office in person or in writing.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature

Date

Witness—THHLVA

Date