

**CARDIOLOGY CONSULTANTS, PC
PATIENT CONTACT INFORMATION SHEET**

Patient Name: _____

Date of Birth: _____ **Social Security No:** XXX-XX-_____

Any physician, staff, employee or representative of Cardiology Consultants, PC, has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number (s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Cardiology Consultants, PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s).

Patient signature: _____ Date: _____