Cardiology Consultants of Houston, PLLC

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Consent for Communication of Protected Health Information

I, _____, give my consent to Cardiology Consultants of Houston, PLLC to release Protected Health Information (i.e. results of laboratory tests, diagnostic testing results or my medical condition) and financial information to the following persons:

Name of Person	Relationship	Phone Number

OR

_____ **NO OTHER PERSON(S)**
Initials

- **PHONE NUMBERS:** At which phone numbers would you like to receive calls about appointment, financial or medical information? ***[check all that apply]***

  ☐ Home ☐ Cell ☐ Work ☐ Other: _____

- **VOICE MAIL:** May appointment, financial or medical information be left on your answering machine or voice mail?

  ☐ Yes ☐ No

- **EMAIL:** When communicating through email, may we include appointment, financial or medical information?

  ☐ Yes ☐ No Email:_____

Name of Patient (Please Print)	Date of Birth
Signature of Patient	Date