Alabama Cardiovascular Group, P.C.

PATIENT CONTACT INFORMATION SHEET

Patient Name: ____

Social Security Number: ____

Any physician, staff, employee or representative of Alabama Cardiovascular Group, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatment, 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
________________________	__________________	_______________
________________________	__________________	_______________
________________________	__________________	_______________
________________________	__________________	_______________

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 Alabama Cardiovascular Group, P.C. or completing a new form at any time. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individuals(s).

Patient Signature: ________________________________ Date: ________________

VERBAL INFORMATIN ONLY