

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

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
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 INFORMATION ONLY