Montgomery Cardiology LLC

PROTECTED HEALTH INFORMATION RELEASE

Please check all that apply and list name(s) of spouse, child(ren) and others involved in care as applicable.

- [ ] You have permission to leave information on my answering machine regarding my medical care and test results.
- [ ] You have my permission to speak with my spouse about my medical care.
- [ ] You have my permission to talk with my children or other family members involved with my medical care.
- [ ] Other, please describe

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Name:	Relationship:	Contact #:

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Name: ______________________________ DOB: ______________

Signature: ______________________________ Date: ______________