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) 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