SOUTH DENVER CARDIOLOGY

Authorization for Communication

I,_____, _____
(patient or patient's legal representative name) *(date of birth)*

Authorize South Denver Cardiology staff to use verbal communication to disclose my health information as it pertains to care and treatment. South Denver Cardiology may verbally disclose my health information to the following individuals:

_____ _____
Primary caregiver name/relationship Address/phone

_____

_____ _____
Name/Relationship Address/phone

_____

_____ _____
Name/Relationship Address/phone

_____

_____ _____
Name/Relationship Address/phone

_____

I understand that I have a right to revoke this authorization at any time, and that if I revoke this authorization, I must do so in writing and present my written revocation to South Denver Cardiology. I also understand that the revocation will not apply to information released prior to receipt of such revocation.

I understand this request will remain in effect until I notify South Denver Cardiology in writing with any changes. I understand authorizing the verbal disclosure of my health information is voluntary. I need not sign this form to ensure health care treatment.

_____ _____
Signature of patient Date

_____
Printed name of patient