CARDIOVASCULAR HEALTH CLINIC
ADVANCED INTERVENTIONAL RADIOLOGY SOLUTIONS

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Release of Protected Health Information to Family Members and Persons Involved in Patient's Care

With your permission, CardioVascular Health Clinic may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, CardioVascular Health Clinic may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or procedure or provide the person with a copy of a prescription. Pharmacies will also be notified or sent a list of your medications if required for the continuance of care. By completing the top portion of this form, you are authorizing CardioVascular Health Clinic to release this information to these individuals. However, you are not authorizing CardioVascular Health Clinic to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate HIPAA authorization form. Please be aware that CardioVascular Health Clinic may use its professional judgement in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name	Relationship

Authorization to Leave Voice Mail and Email Messages

CardioVascular Health Clinic is required to have your permission to leave voice messages or send email messages regarding your Protected Health Information (test results, instruction, etc.) Please check the appropriate boxes:

☐ Yes, CardioVascular Health Clinic may leave a message on my answering machine/voice mail regarding my Protected Health Information.

☐ No, CardioVascular Health Clinic may not leave a message on my answering machine/voice mail regarding my Protected Health Information.

☐ Yes, CardioVascular Health Clinic may email me a message regarding my Protected Health Information.

☐ No, CardioVascular Health Clinic may not email me a message regarding my Protected Health Information.

I understand that if I change my mind about any of the information in this form, I must contact CardioVascular Health Clinic to revoke this form in its entirety or to complete a new form.

Patient's Signature _____ Today's Date _____

Print Patients Name _____ Verbally Taken by (CHC Employee) _____

Patient Date of Birth _____ Witness (CHC Employee) _____