Heart of Texas Cardiology, P.A.
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Communication and Restrictions of Private Health Information (PHI)

Patient Name: _____ DOB: _____

The above name patient has requested confidential communication and/ or restrictions of the use disclosure of his/her PHI.

The following person are *able to receive and access any of my PHI, including billing information:*

Name: _____ Relationship: _____Phone: _____
Name: _____ Relationship: _____Phone: _____
Name: _____ Relationship: _____Phone: _____
Name: _____ Relationship: _____Phone: _____

We *are* authorized to orally communicate with me by calling me at the following phone numbers:

Home: _____ Cell: _____ Work: _____ Ext: _____

We *may* leave a message on the above numbers: Y ____ N ____

We *may* leave a call back message on the above numbers: Y ____ N ____

We *may* leave an appointment reminder on the above numbers: Y ____ N ____

We are authorized to communicate with me in writing at the following addresses:

Home: _____
Work: _____
Other: _____

We may send an appointment reminder to my home address: Y ____ N ____

_____ _____
Patient/ Guardian Signature Date

_____ _____
Person designated as my Power of Attorney Signature Date