

CARDIOLOGY CONSULTANTS OF TEXAS

Diagnostic and Interventional Cardiology

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Patient Preference Regarding Communication of Health Information

Patient Name: _____ **ID#** _____

I. Who to Contact

I hereby give permission to CCT to disclose and discuss any information related to my medical condition(s) to/with the following family members(s), other relative(s) and/or close personal friend(s):

Name Relationship

Name Relationship

Name Relationship

_____ I do not wish to disclose any information with anyone.

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:	Cell Phone:
<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only

Written Communication

OK to mail to my home address _____

OK to mail to my work/office address _____

OK to fax to this number _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative

Date

621 N. Hall, Suite 400
Dallas, Texas 75226
214-824-8721

4211 Joe Ramsey Blvd., Suite 108
Greenville Texas 75401-7852
903-408-7870

1305 W. Jefferson, Ste. 100
Waxahachie, Texas 75165
972-923-7292

301 E. Ovilla Road, Ste 100
Red Oak, Texas 75154
214-824-8721