West Chester Cardiology
www.westchestercardiology.com

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PATIENT DISCLOSURE AUTHORIZATION

With your permission, we can provide information to you in a variety of ways. Please indicate agreement with the following list by checking all that apply:

Patient Name: _____

Signature: _____

☐ It is acceptable for you to leave information on my answering machine, including appointment reminders.

*Phone No. _____

☐ I do not want you to speak with any family members or friends regarding my condition.

☐ It is acceptable for you to speak with only the following family members/friends regarding my condition: (please check all that apply):

- ☐ Spouse (please indicate name) _____
- ☐ Sibling (please indicate name) _____
- ☐ Children (please indicate name) _____
- ☐ Friend (please indicate mane) _____
- ☐ Other (please indicate name) _____

It is the patient's responsibility to notify the office of any changes to this Authorization.