West Chester Cardiology
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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.