DALLAS
Heart & Vascular
CONSULTANTS

Authorization Form For
Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below to family members or other persons of my choosing as designated on the document.

Patient Name: _____ **Date of Birth:** _____

My PREFERRED Method of Contact is:
(Check one that is PREFERRED & provide all additional contact information below)

_____ Telephone (Cell/Home/Work) My number is: _____

_____ Text Message. My number is: _____

_____ E-Mail. My e-mail address is: _____

Check all that apply below:
_____ It is O.K. to leave me a message with detailed information. _____ It is NOT O.K.

_____ It is O.K. to contact me at work. My number is: _____

_____ It is O.K. to leave me a message at work with detailed information.

_____ It is NOT O.K. to leave me a message at work with detailed information

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

_____ My spouse, whose name is: _____ Phone: _____

_____ My parent, whose name is: _____ Phone: _____

_____ My child, whose name is: _____ Phone: _____

_____ No one other than myself

_____ Fill in any other name you desire: _____

_____ _____
Signature of Patient or Personal Representative **Date**