Heart Failure Survival Center of America, SC
Oral Disclosure

Patient Name: _____ Patient Date of Birth: _____

Identification of Communication Disclosure for family members/friends/caregivers:

I authorize communication with the following person(s) involvement regarding my heart information that is directly relevant to their involvement with my care or payment related to my care. These communications will when identified person(s) accompany me on my clinic visit, or communicate on my behalf by telephone or electronic method.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I understand that the release of my detailed medical records requires a specific authorization form signed by myself.

Can we leave a message on an answering machine or with a family member, regarding appointments, prescriptions or financial issues: **Yes or No**

Can we take your picture as another form of verification to be placed in your Electronic Health Record: **Yes or No**

Does the patient have an Active POA (Power of Attorney) or Legal Guardian? Yes or No

If yes, Name: _____

Signature of Payment: I request that payment of authorized Medicare or other insurer benefits be made either to me or on my behalf to Heart Failure Survival Center of America for any services furnished to me by or in Heart Failure Survival Center of America and it's providers, including physician services. I authorize the release of any medical information about me to CMS or other insurer or agency for the purpose of processing the claim or related claims.

This disclosure form is in effect until I change or revoke it. Only I can change who is named on this form to receive my health information. At that time of change or revocation a new form will be completed.

Signature: _____ Date: _____
(Patient or person legally authorized to sign for the patient)

Printed Name: _____