LAKEWOOD CARDIOVASCULAR CONSULTANTS, PA

INFORMATION DISCLOSURE

Patient Printed Name: _____

According to HIPPA regulations, we must obtain permission to leave medical information on voice mails, answering machines or with persons other than you.

Please fill out and sign below.

__ With my consent, Lakewood Cardiovascular Consultants may leave a message on my home answering machine or voice mail.

__ With my consent, Lakewood Cardiovascular Consultants may leave a message on my work voice mail.

__ With my consent, Lakewood Cardiovascular Consultants may leave a message on my cell phone voice mail.

__ With my consent, Lakewood Cardiovascular Consultants may mail to my home or other designated location any items that assist the practice in carrying out items such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

__ With my consent, Lakewood Cardiovascular Consultants may leave a message with the following people: (please include name and phone number)

I may revoke my consent in writing except to the extent that the practice has already made the disclosures in reliance upon my prior consent. If I do not sign the consent, Lakewood Cardiovascular Consultants, PA may decline to provide treatment to me.

_____ _____

Patient's Signature Date