Heart of Texas Cardiology, P.A.

2911 Medical Arts Street, Bldg 10
Austin, Texas 78705
512-474-5551 Fax: 512-474-7324

Communication and Restrictions of Private Health Information (PHI)

Patient Name: _____ DOB: _____ SS#: _____

The above name patient has requested confidential communication and/or restrictions of the use and disclosure of his/her PHI.

The following persons are ***able to receive and access any of my PHI, including billing information:***

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

We ***are*** authorized to orally communicate with me by calling me at the following phone numbers:
Home: _____ Work: _____ Cell: _____

We ***may*** leave a message on the above numbers: Y _____ N _____

We ***may*** leave a call back message on the above numbers: Y _____ N _____

We ***may*** leave an appointment reminder on the above numbers: Y _____ N _____

We are authorized to communicate with me in writing at the following addresses:

Home: _____
Work: _____
Other: _____

We may send an appointment reminder to my home address: Y _____ N _____

_____ _____
Patient/Guardian Signature Date

_____ _____
Person designated as my Power of Attorney Signature Date