Heart of Texas Cardiology, P.A.
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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:***

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