Patient Name:_____ D.O.B._____

In an effort to improve communication with you we are requesting your authorization to leave voicemails, on the phone number you designate, regarding your appointments, lab and test results, health maintenance, medications, prescriptions, and other general notifications. Please check the following preferences below:

☐ I authorize Heart Specialty Associates to leave voice messages with the information as set forth above on the phone number set forth below.

_____

Type (circle): Cell Home Work

☐ I do not give permission to leave detailed voice mail messages.

_____ You may at any time release my confidential health information and/or written prescription medications to: (if no names are listed, we will not release any information or written prescription.)

NAME	*RELATIONSHIP TO PATIENT*	*PHONE NUMBER*	☐ *PRIMARY CAREGIVER* ☐ *GUARDIAN*
NAME	*RELATIONSHIP TO PATIENT*	*PHONE NUMBER*	☐ *PRIMARY CAREGIVER* ☐ *GUARDIAN*
NAME	*RELATIONSHIP TO PATIENT*	*PHONE NUMBER*	☐ *PRIMARY CAREGIVER* ☐ *GUARDIAN*

SIGNATURE OF PATIENT/GUARDIAN *PRINTED NAME* *DATE / TIME*

St. Anthony's
St. Louis, Missouri 63128

Heart Specialty Associates

PERMISSION TO CONTACT AND RELEASE OF INFORMATION