Patient Name: _____

EMR Number: _____
(office use only)

The Stern Cardiovascular Foundation

COMMUNICATION CONSENT

I authorize Stern Cardiovascular and their staff to verbally discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment, billing, and other health related information) with the persons listed below.

I understand that by leaving spaces blank that I am indicating my choice to be "No Information" and I do not want any verbal information released to anyone other than myself.

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
		( )
		( )
		( )
		( )
		( )

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I may revoke my consent by notifying the Stern Cardiovascular Foundation.

_____ _____

Signature of Patient or legal representative **Date**