

Please communicate with me in the following manner (check all that apply):

- My home telephone number is: \_\_\_\_\_  
 OK to leave a message with detailed information       OK to leave a message with call-back number only
- My work telephone number is: \_\_\_\_\_  
 OK to leave a message with detailed information       OK to leave a message with call-back number only
- My cell phone number is: \_\_\_\_\_  
 OK to leave a message with detailed information       OK to leave a message with call-back number only
- Written communication:  
 OK to mail to my home address       OK to mail to my work/office  
 OK to e-mail to the following address: \_\_\_\_\_  
 OK to fax to the number provided: \_\_\_\_\_

You may disclose my healthcare information to and discuss my healthcare needs with the following individual(s):

Name of Individual	Relationship to Patient
_____	_____
_____	_____
_____	_____

*I authorize Medicare and/or my commercial insurance company to make payment directly to Saint Luke's Cardiovascular Consultants on services I receive from their providers. I understand that any balances not reimbursed by my insurance company will become my responsibility. I further authorize the release of any necessary medical records information to any carrier listed on the claim for the purpose of processing the insurance claim. I also authorize the release of my medical records to my insurance company upon request for information regarding my medical status.*

Check applicable box:

- You have offered and made available, but I am electing **not** to receive, a copy of Saint Luke's Cardiovascular Consultants Notice of Privacy Practices, dated April 1, 2003.
- I acknowledge receiving a copy of Saint Luke's Cardiovascular Consultants Notice of Privacy Practices, dated April 1, 2003.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Account #                      Patient's DOB                      Patient's Social Security #

\_\_\_\_\_  
Signature of Patient or Personal Representative\*                      Date

*\* IF SIGNED BY A PERSONAL REPRESENTATIVE, THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED:*

\_\_\_\_\_  
*Name of Personal Representative & Description of the Personal Representative's authority to act on behalf of the patient*

[Office Notes: \_\_\_\_\_]