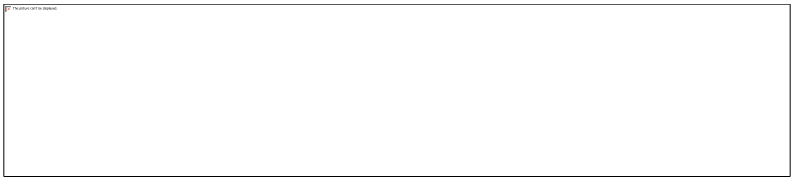

# Patient HIPAA Consent Form

## Authorization to Disclose Protected Health and/or Billing Information

I give Pensacola Cardiology, PA and its representatives to share my health and/or billing information to the following:

Name:_____Relationship to Patient:_____

Address:_____Telephone #:_____

Name:_____Relationship to Patient:_____

Address:_____Telephone #:_____

Name:_____Relationship to Patient:_____

Address:_____Telephone #:_____

Please read over and initial the following statements:

- I understand that anyone in the examination room will hear my private health information. _____initials
- I give permission to Pensacola Cardiology, PA to leave a detailed message on the following phone numbers: _____ _____. _____ initials

Patient Signature: _____ Date: _____

Patient Representative (if patient unable to sign or under 18):

_____ Date: _____

Description of Representative's Authority: _____