Colorado Cardiovascular Surgical Associates, P.C.

PERSONAL HEALTH INFORMATION DISCLOSURE AUTHORIZATION

Patient Name:_____

Date:_____ Acct #:_____

Names of family / friends with whom we may discuss your treatment / health information

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Patient / Legal Representative Signature:_____

Relationship to Patient:_____Date:_____