

CONSENT TO DISCUSS

Patient Name: _____
(Please Print Legal Name)

DOB: _____

Patient's Account Number: _____

I AUTHORIZE Cardiology Associates of Virginia to discuss my medical information with the following individuals I have listed below. (Please Print)

Legal Name Relationship

Legal Name Relationship

Legal Name Relationship

Cardiology Associates of Virginia has my permission to leave medical information at my home telephone number.

YES

NO

(Signature of Patient)

Date

(Printed Name of Signature)

