

# Hillsboro Cardiology, P.C.

Physicians, Board Certified in Cardiovascular Diseases

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## CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, authorize Hillsboro Cardiology, PC and Center for Vein Therapy to disclose my personal health information consisting of:

- |   |  |
|---|--|
| <input type="checkbox"/> Office visit notes | <input type="checkbox"/> Billing and payment information |
| <input type="checkbox"/> Lab results        | <input type="checkbox"/> Procedure reports               |
| <input type="checkbox"/> Study results      |  |

TO:  
(please print)

Authorization Expires:

Name: \_\_\_\_\_  Never or Date: \_\_\_\_\_

Name: \_\_\_\_\_  Never or Date: \_\_\_\_\_

Name: \_\_\_\_\_  Never or Date: \_\_\_\_\_

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form. I understand that I may revoke this authorization at any time by providing a written request to Hillsboro Cardiology, PC and Center for Vein therapy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_