# *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:

☐ Office visit notes ☐ Billing and payment information
☐ Lab results ☐ Procedure reports
☐ 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 an 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: _____




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