Elite Cardiovascular Group
Dr. Nalluri & Dr. Asti

Protected Health Information (PHI) Communication Consent Form

At Elite Cardiovascular Group, we would like to understand your preferred method(s) of communication and obtain your consent for releasing medical information to family members and other individuals of your choice. You give us permission to relay your medical information such as lab results, prescription requests, appointment reminders, and referrals via phone, fax, post mail, or other specified methods as selected below. You also give us permission to release medical information to your family members, caregivers, or other selected individuals according to your preferences below. By signing this form, you understand that you have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. This form is optional and does not expire. Your request will be in effect until you notify our practice of any changes.

Name: _____ DOB: _____ Medical Record #: _____

Methods of Communication (check all that apply):

Home Telephone: _____

- ○ Leave a voice message
- ○ Do not leave a voice message

Work Telephone: _____

- ○ Leave a voice message
- ○ Do not leave a voice message

Cell Phone: _____

- ○ Leave a voice message
- ○ Do not leave a voice message
- ☐ Text message

Written Communication:

- ○ Send to home address
- ○ Send to work address
- ☐ Fax to this number: _____

Secured e-messaging through Online Patient Portal (must be 18 years of age or older)
Email to access patient portal: _____

☐ Messaging via Healow & ECW

Others: _____

Permission(s) (check all that apply):

○ I do not want my medical information to be communicated to my family members or caregivers

○ I give this practice the permission to verbally communicate my medical information to family members, caregivers, or other individuals listed below:

Name: _____ Phone: _____

Relation: _____

Name: _____ Phone: _____

Relation: _____

Information to be released/accessed (check all that apply):

☐ Appointment Information ☐ Prescription Drug Information ☐ Referral Information

☐ Lab Results ☐ Medical Instructions/Advice ☐ Billing, Insurance, & Payment Information

X _____ _____
Patient/Guardian Signature Date

_____ _____
Print Name DOB