CARDIOVASCULAR CONSULTANTS P.C.

Authorization to Receive Communications from Cardiovacular Consultants PC

I, _____, authorize Cardiovacular Consultants to leave messages regarding my health care with the following person(s).

1._____Phone_____

2_____Phone_____

3_____Phone_____

4_____Phone_____

5_____Phone_____

_____ _____ _____
Printed Name of Patient Signature Date

_____ _____ _____
Printed Name of Witness Signature Date

_____ _____
Office Representative Signature Date