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**PEE DEE
CARDIOLOGY
ASSOCIATES, P.A.**
Caring for the Hearts of the Pee Dee

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

As a patient of Pee Dee Cardiology Associates, PA, I hereby authorize Pee Dee Cardiology to release all information regarding my medical condition to the following family member(s) and/or caregiver listed below:

<u>NAME</u>	<u>RELATIONSHIP TO YOU</u>
_____	_____
_____	_____
_____	_____

I **do not** wish to release my medical records or information regarding my medical condition to any family member and/or caregiver at this time.

Signature: _____

Print Name: _____

I give permission to the staff at Pee Dee Cardiology to leave messages for me on my answering machine or voice mail regarding appointments, test results, or other information that needs to be relayed in a timely manner.

Signature: _____

Print Name: _____

I understand that I can make changes to the above authorization at any time and will notify Pee Dee Cardiology in writing if I wish to make changes.

(Patient Initials)

Pee Dee Cardiology, its employees, officers, and physicians are hereby released from any responsibility for disclosure of the above information.

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

