Three Rivers Cardiac Institute
April 2003
Consent to Disclosure of Personal Health Information to Family Members

I, _____, give my permission to the practitioners and staff of Three Rivers Cardiac Institute to release information regarding my medical care, including my medical condition, test results, appointment dates/times to the following individuals:

Name	Relationship	Telephone Number

_____
Name of Patient

_____ _____
Signature of patient (or personal representative) Date

Personal Representative Name:

Relationship/Authority: