Disclosure to Family/Friends Form

___ I do not want Gainesville Heart and Vascular Group ("Provider") to disclose any information concerning my care, treatment or billing by Provider to individuals without my express written consent or legal authorization.

___ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

_____ _____

_____ _____

_____ _____

___ I authorize Provider to discuss information related to my bill with the following named individual(s):

_____ _____

_____ _____

_____ _____

**** We will **only** release information to individual(s) named on this form.

The authorization provided for the above are subject to the following limitation or restrictions:

_____

_____

_____

_____ _____

Patient Name (Printed) acct # Date

_____ _____

Patient Signature or legally responsible person Date

_____ _____

Witness Date