

# Coventry Cardiology Associates Telephone Contact Release Form

I understand that it is important that Popkave-Mascarenhas Cardiology be able to contact me via telephone in order to confirm appointments and review test results.

I, \_\_\_\_\_, do hereby authorize Popkave-Mascarenhas Cardiology to call my home to confirm or cancel appointments and to release results of testing such as blood work, Holter monitoring, echocardiogram, vascular, nuclear testing, and x-rays.

In my absence, I authorize the above information to be released to the following:

Husband Name: \_\_\_\_\_

Wife Name: \_\_\_\_\_

Daughter Name: \_\_\_\_\_

Son Name: \_\_\_\_\_

Other Name: \_\_\_\_\_

Answering Machine

This authorization will remain in effect for the term of one year. I understand that should I decide to revoke this authorization prior to its expiration, I must do so in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_