

AUTHORIZATION FOR PAYMENT:

I hereby authorize payment directly to the provider of services, and I understand that I am responsible for medical charges, co-pays and/or deductibles not covered by my insurance company.

I am aware that I, not my insurance company, am responsible for the entire account. I understand that my insurance is a contract only between my insurance company and myself and not with ***Birmingham Heart Clinic, P.C.***

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physicians and/or staff of ***Birmingham Heart Clinic, P.C.*** to release medical information such as office notes and/or test results to myself, person (s) listed below and/or other physicians assisting with my medical care until notified otherwise.

AUTHORIZATION TO RELEASE TEST RESULTS:

I hereby authorize the physicians and/or staff of ***Birmingham Heart Clinic, P.C.*** to discuss my medical condition and/or test results:

Please check all that apply:

only to myself

leave test results on answering machine

only to the following persons:

Phone: _____

Phone: _____

Phone: _____

Patient's Name *(please print)*

D/O/B

Patient's Signature

Date

Witness

(This authorization is valid unless notified in writing by the patient.)