Hearts South, PC
Specialists in Cardiovascular Care

Darius G. Aliabadi, MD, FACC, FSCAI
Donna L. Trimnel, Administrator

Hollie B. Crutchfield, DNP, CRNP, FNP-BC
Marla Hodge, CRNP, FNP-BC

Medical Information Release

Due to federal privacy guidelines under the Health Insurance Portability and Accountability Act (HIPAA), we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to family members, caregivers, and friends you have designated, about your HEALTH INFORMATION. Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, phone, fax, mail or e-mail as needed for your care to only those identified below. Powers of Attorney would be listed separately.

Please list names, date of birth and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

I _____ (patient name) give my authorization to the following individual(s) listed below to discuss my medical care with you and/or your staff on my behalf.

Names	Date of Birth	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list below any health information that you do not want to be given out.

_____

_____

☐ **I DO NOT want you to discuss my medical care with ANYONE other than myself.**

Our office staff may attempt to contact you by telephone concerning your upcoming appointments or test results. If we are unable to reach you at that time, please indicate below your choice for the best way to contact you:

☐Family member at my home
☐Leave a message at my place of business
☐Voice message on my cell phone
☐Answer machine at my home

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed or until we receive written notification from you to revoke it.

Signature _____ Date _____

Witness _____ Date _____

Revised 07/31/09
Form-Med.rel.4/14/03-#1

Doctors Building, Suite 403 · 1118 Ross Clark Circle · Dothan, Alabama 36301

(334) 793-5672 · 1-800-293-5672 · FAX: (334) 794-0378

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PATIENT INFORMATION/MEDICAL COST AGREEMENT TO PAY

Patient's Name: _____ Age: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Marital Status: (circle one) S M W D Race: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____ Extension: _____

Social Security Number: _____ Referring Physician: _____

Place of Employment: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

If minor, Responsible Party: _____ Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Phone: _____

In case of emergency, who should be notified? _____

Phone No.: _____ Relationship to Patient: _____

INSURANCE INFORMATION

1. PRIMARY:

_____ Contract # _____ Group # _____
Name of Carrier

Insured's Information If Other Than Patient:
Date of Birth: _____ Relationship to Patient: _____ Place of Employment: _____

2. SECONDARY:

_____ Contract # _____ Group # _____
Name of Carrier

Insured's Information If Other Than Patient:

Date of Birth: _____ Relationship to Patient: _____ Place of Employment: _____

PATIENT'S OR AUTHORIZED SIGNATURE: I authorize the release of any medical information needed to process my insurance claims. I also request payment of benefits to Hearts South, P.C. for services rendered. This signature shall suffice for all claims on a continuing basis. A copy of this authorization may be used in place of original.

SIGNED: _____ DATE: _____

RELEASE OF MEDICAL RECORD: In order to insure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to Hearts South, P .C., my physician, a designated referring physician and/or the provider, if any, who referred me here.

SIGNED: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices from Hearts South, P.C.

_____ _____
Patient or Personal Representative Date

MEDICAL COST AGREEMENT TO PAY
(continued)

The Patient and Responsible Party listed above hereby agree to pay any and all amounts and charges submitted by Hearts South, P.C. on behalf of the professional corporation set forth above for services rendered by any and all physicians who are now employed or become employed by such professional corporations or affiliated with Hearts South, P.C., (hereinafter referred to as "Physician"), or any of their agents, employees or contractors, during the course of treatment for the Patient, including hospitalization, unless such parties are otherwise obligated to accept payment solely from a third party. The Patient and the Responsible Party hereby acknowledge, understand, and agree that they are financially responsible for payment for such professional services even though there may be insurance or third party coverage, and agree that failure to make payment when requested is the basis for legal action, and all agree to pay any and all costs of collection including a reasonable attorney's fee to the extent permitted by law. The Patient and Responsible Party hereby acknowledge their understanding that the payment is due upon receipt of invoice statement, and agree to pay a 1.5% per month late charge on all accounts over thirty (30) days past due. The Patient and the Responsible Party recognize and agree that their obligations to make payment are joint and severable and that they, and not any insurance company, are solely responsible for the entire bill, even though the cost of the medical care may exceed the amount reimbursed by the third-party insurers or payors.

The Patient and the Responsible Party hereby acknowledge, understand, and agree that it is difficult to project the full cost of medical services and treatments in advance, since it is impossible to know what services, tests, procedures, and/or treatments will be required in the course of medical care.

The Patient and the Responsible Party hereby agree to be fully responsible for any and all amounts and charges submitted by the Physicians in the course of treatment or any of their agents, employees, or contractors, which shall include, but shall not be limited to, the amounts set forth on the fee schedule attached hereto or kept at the front desk by Hearts South, P.C., (which I[we] acknowledge is available to me [us]). The Patient and the Responsible Party acknowledge that the charges may exceed the amount Blue Cross or another insurance carrier may define as "usual and customary, or reasonable", but the Patient and Responsible Party agree to pay the amount of such billed charges.

I, the undersigned, understand and agree to the above information.

DATE: _____ _____

PATIENT

DATE: _____ _____

RESPONSIBLE PARTY

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Authorization for Request of Protected Health Information (PHI)

Please release to:
Hearts South, PC
1118 Ross Clark Circle Suite 403
Dothan, AL 36301

I authorize the release of my protected health information:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Social Security Number: _____

The type and amount of information requested is as follows:
☐Complete Medical Record ☐Medical Discharge Summary ☐History and Physical
☐Nursing Summary ☐Operative Notes
☐Lab Report (Specify) _____ ☐Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from date signed.

I understand that I may inspect or copy the information to be used or disclosed, as provided in Notice of Privacy Practices. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information or to present my written revocation authorization I can contact: Donna Trimnel, Administrator 1118 Ross Clark Circle Suite 403 Dothan, AL 36301.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient (if applicable)

_____
Witness