I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance, in the opinion of Alabama Heart & Vascular, P.C. and/or for assisting in any reimbursement or medical benefits to which the patient may be entitled. I allow fax transmittal of my medical records, if necessary. I further authorize and request that insurance payments be made directly to Alabama Heart & Vascular, P.C. should they elect to receive such payment. This is a direct assignment of my right and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by Alabama Heart & Vascular, P.C. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by Alabama Heart & Vascular, P.C. physicians and personnel.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization. This authorization is valid for one year.

I have read and fully accept financial responsibility in full for this account.

Patient Signature: _____ Date: _____

Print Name: _____