PEDIATRIC CARDIOLOGY OF MONTGOMERY
Barton B. Cook, M.D., F.A.C.C.
Gerardo S. Gonzalez, M.D., F.A.C.C.

Fran Jackson, Administrator
Email: *fjackson@psm239.com*

239 Mitylene Park Drive
Montgomery, AL 36117
Phone: 334-612-2111
Fax: 334-612-2166
childrensheartdoc.com

New Patient Consent to the Use and Disclosure of Medical Records for Treatment, Payment, or Healthcare Options

I, _____, understand that as part of my healthcare, Pediatric Specialists of Montgomery originates and maintains paper and/or electronic records describing my health, symptoms, examination and test results, diagnoses, treatment and any plans for future health care treatment. I understand that this information serves as:
(1) A basis of communication among the many health professionals who contribute to my care (2) A source of information for applying my diagnosis and surgical information to my bill (3) A means by which a third-party payer can verify that services billed were actually provided, and (4) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions.

I understand and have been provided with a *Notice of Privacy Policies* that provide a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
(1) The right to review the notice prior to signing this consent (2) The right to reject the use of my health information for directory purposes, and (3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

In addition to myself, I consent to the following adult individuals to have access to my medical records: (please give full name and address) (athletes should consider their coaches and trainers)

_____

_____

I understand that Pediatric Specialists of Montgomery is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Pediatric Specialists of Montgomery reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information

By my signature below I acknowledge that I have received the Privacy Notice of Pediatric Specialists of Montgomery, L.L.C. I understand that the physicians and staff of Pediatric Specialists of Montgomery, L.L.C. WILL NOT discuss my health information with my family or friends unless I expressly authorize them to do so. This authorization may be revoked at any time by me in writing. I hereby authorize the physicians and staff of Pediatric Specialists of Montgomery to convey information about my health to the following people:

Name: _____ Relationship _____

Name: _____ Relationship _____

Pediatric Specialists of Montgomery will call your home telephone to remind you of your appointment unless directed not to by you. If you have caller ID any calls from us will register. Please check one:

- ☐ Do NOT call me at all.
- ☐ Call me and leave a message on my answering machine/ voicemail if there is no answer
- ☐ Call me but do NOT leave a message on my answering machine/ voicemail.

EXPRESS PRIOR CONSENT TO CALL CELL PHONE:
I, the undersigned, give Pediatric Specialists of Montgomery , it's employees, and/or agents express prior consent to contact me at any/all phone numbers, including cell phone numbers, (by phone call or text message), for the purpose of insurance, treatment, and payment.

_____
Patient's Signature/Parent/Guardian

_____
Date

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____