Authorization and Consent Form

_____ I authorize **Minnesota Women's Care, P.A.**, on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by **Minnesota Women's Care, P.A.**, to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled and I request payment of all such authorized benefits be made on my behalf to **Minnesota Women's Care, P.A.** for any services furnished by **Minnesota Women's Care, P.A.**

_____ I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from **Minnesota Women's Care, P.A.** or any other provider, with **Minnesota Women's Care, P.A.**, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

_____My insurer may share my past, current and future health and account records with **Minnesota Women's Care, P.A**. about services I've received from **Minnesota Women's Care, P.A.** and other care providers unrelated to **Minnesota Women's Care, P.A.** These records may be used by **Minnesota Women's Care, P.A.**, as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

OR Initial _____ My insurer may not release any of my identifiable health records from providers unrelated to **Minnesota Women's Care, P.A**. for the purposes described above.

_____ I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage. If circumstances require the use of a third party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary. Currently the collection agency charges 38% of the fee owed. I understand that this will be my responsibility to pay in addition to the amount owed.

_____ I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

_____ I authorize **Minnesota Women's Care, P.A.** to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. **Minnesota Women's Care, P.A.** may call me and, if necessary, leave messages on my answering machine. In addition, the following people may have access to my health information:

Name : _____Relationship: _____

Name : _____Relationship: _____

_____ By initialing, I acknowledge that I have received the Notice of Privacy Practices from **Minnesota Women's Care, P.A.**

. . . . . .

I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at anytime and that my revocation shall have no effect on any actions taken prior to my revocation.

_____ _____

Patient's Name Date

_____

Signature of Patient or Personal Representative

_____

Relationship to Patient (if patient unable to sign)