Authorization and Consent Form

Patient Label

Please initial each line below:

_____ **General Release of Information & Assignment of Benefits:**
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.,**

_____ **Release of Information by Payers and Networks:**
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.

_____ **Insurance Disclosure:**
My insurer may share my past, present, 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.,** 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 manager or coordinate my care and to improve the quality of 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 MNWC for the purpose described above.

_____ **Payment Agreement:**
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 it is our office policy that all past due accounts be sent three statements. If payment is not made on the account, the account will be sent to an outside collection agency with possible dischagre from the practice. Your account will be assessed a 25% processing service fee when sent to collections. If this is to occur you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

_____**Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers:**
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.

_____ **Messages:**
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: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

_____ **Patient Information:**
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

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship to Patient (if patient is unable to sign) Date