MRO
Minneapolis Radiation Oncology, P.A.

PATIENT AUTHORIZATION AND CONSENT FOR SERVICES

Release of Medical Records for My Medical Care or As Required by Law: I agree that a copy of my medical records that was created, received, and maintained by Minneapolis Radiation Oncology, P.A. (MRO, P.A.) may be sent:
- to health care providers directly involved with my care
- to state, federal and accrediting bodies for required reporting data and/or surveys for compliance
- to MRO, P.A. affiliates for purposes of my medical care and for business operations

I authorize release of protected health care and financial information to the following people (family/significant other/etc.):

List by name(s): _____

Emergency Contact(s): _____ **Phone(s):** (____) _____

I give permission to contact and leave **me** messages at the following phone numbers:

Home: (____) _____ Cell: (____) _____ Work: (____) _____

If I cannot be reached, it is ok to contact:

1) Name: _____ Phone: (____) _____

2) Name: _____ Phone: (____) _____

3) Name: _____ Phone: (____) _____

Bill My Insurance/Assignment of Benefits:
- I authorize MRO, P.A. to send my bills for medical care and treatment to my insurance company, other payer, and/or Medicare or Medicaid for payment, to the extent my insurance company, other payer, and/or Medicare or Medicaid is required to pay the bill under the terms of my insurance policy or by law.
- I request that my insurance company, other payer, and/or Medicare or Medicaid pay MRO, P.A. or other providers who are involved in my treatment.
- I consent to the release of my medical record by MRO, P.A. to my insurance company, other payer, and/or Medicare or Medicaid (and other organizations working on their behalf) if necessary in order for my bills to be paid.
- I agree to pay for any charges not covered by my insurance.

Consent for Services: By signing this form:
- I voluntarily consent to evaluation and diagnostic testing which my physician determines to be necessary.
- I consent to the taking of photographs for medical record documentation.
- I consent to the review of my medical records and release of this information to Cancer Data Services.
- I am aware that MRO, P.A has health care personnel in training that may be present during care as part of their education.
- I understand that I am responsible to comply with the rules and regulations of my insurance company regarding precertification and prior authorization requirements.
- I understand that I am responsible for my bill.
- I am authorizing MRO, P.A. to electronically access and view my medication history for treatment purposes. I am also authorizing MRO, P.A. to electronically review information regarding drug benefit coverage, electronically order and send prescriptions, and electronically receive refill requests.
- I am acknowledging that I am in receipt of MRO, P.A.'s Notice of Privacy Practices and understand that MRO, P.A. has the right to change this Notice at any time. I may obtain a current copy by contacting this Radiation Therapy Center or MRO, P.A. This Notice provides more details on the treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this form, please ask for one.
- **I am acknowledging that this Radiation Therapy Center is physician owned and operated.** For purposes of billing, it is considered an office. It is not operated by any hospital and our services are not considered hospital services.
- I understand that this consent will expire one year from date of signature; however I may revoke this consent for release of protected health information at any time by notifying MRO, P.A. in writing at 6950 France Avenue S., Suite 200, Edina, MN 55435; but that such revocation will not apply to information already released.
- **I am acknowledging that I am in receipt of MRO, P.A.'s "Business Procedures" Information. Initial:** _____

Patient Signature: _____ Date: _____

Print Patient Name: _____

Legal Representative: _____ Reason Patient Unable to Sign: _____