



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: _____ Relationship: _____ Phone: (____) _____

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 7401 Metro Blvd, Suite 210, Edina, MN 55439; 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: _____