# 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

**Emergency Contacts and Release of Information:**

1) **Name:** _____ **Relationship:**_____ **Number:** _____
   Should this person be listed as an Emergency Contact? **Yes** **No**
   Do you authorize the release of protected health care and financial information to this person? **Yes** **No**
2) **Name:** _____ **Relationship:**_____ **Number:** _____
   Should this person be listed as an Emergency Contact? **Yes** **No**
   Do you authorize the release of protected health care and financial information to this person? **Yes** **No**
3) **Name:** _____ **Relationship:**_____ **Number:** _____
   Should this person be listed as an Emergency Contact? **Yes** **No**
   Do you authorize the release of protected health care and financial information to this person? **Yes** **No**

**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 the MRO, P.A. business office, any MRO therapy center, or viewing it online at https://mropa.com/privacy-policy/. 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 understand that this consent will continue forever; 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 "Billing Procedures" Information. Initial:** _____
  If there is not a copy of the Billing Procedures accompanying this form, please ask for one by contacting the MRO, P.A. business office, any MRO therapy center, or viewing it online at https://mropa.com/billingprocedures/regions-methodist.

**Patient Signature:** _____ **Date:** _____

**Print Patient Name:** _____

Legal Representative: _____ Reason Patient Unable to Sign: _____