

CONSENT TO ARRANGE FOR PAYMENT AND RELEASE INFORMATION

We are required by law to ask you to sign this form each year.* This form is important to your privacy rights.

ARRANGING PAYMENT

➤ **Assignment of Benefits and Responsibility for Payment:** *This allows us to bill your health plan and receive payment directly. It also means that you agree to pay for services not covered by your health plan.*

- I authorize my caregiver to bill my health plan and other third-party payers, directly on my behalf, and to receive direct payment of authorized benefits. I agree that it is my responsibility to pay for any healthcare services not covered by my health plan, including but not limited to co-payments, deductibles or co-insurance.

RELEASING INFORMATION

➤ **For Care, Payment and Operations:** *This allows us to coordinate your care with other healthcare providers and to bill for services. This also allows your health plan to process your claims and provide other services to you.*

- I authorize my caregiver to release information from my health records to my other healthcare providers for treatment, payment or healthcare operations.
- I authorize my caregiver to release information from my health records for purposes of processing and paying claims, coordinating benefits, coordinating care, quality of care review studies, and other functions that support treatment, payment and healthcare operations, including those functions that my caregiver is required by my health plan or other third-party payers to perform.
- I authorize my health plan to release my health information to appropriate accreditation and quality review/measurement personnel, to disease, pharmacy, or case management providers and to other third parties for purposes related to treatment, payment, or healthcare operations.

➤ **For Health Research:** *This allows us to share limited information about you with external health researchers. Health research advances new and better ways to prevent, diagnose and treat illness. This research could benefit you and your family directly and the community as a whole. All medical research involving the use and disclosure of individual health records is legally required to get prior review and approval from an Institutional Review Board. The Board is charged with the protection of research subjects, confidentiality and conducting research responsibly.*

- I authorize my caregiver to release limited information about me to external health researchers in accordance with federal law.
- If you do **not** wish to have this information shared with external health researchers, you can check this box.

SIGNATURE AND ACKNOWLEDGEMENT

I understand that I may revoke (cancel) this consent, in writing, at any time. Revoking consent does not apply to information that has already been disclosed. I also acknowledge that a copy of my caregiver's notice of privacy practices has been made available to me. For the purposes of this form, the terms "us", "we" and "caregiver" means the HealthPartners family (for example, HealthPartners Clinics and Regions Hospital) and any entity providing services at a HealthPartners family location as part of the organized healthcare arrangement, as defined in the Notice of Privacy Practices.

Signature

Date

Signature of Parent or Legal Representative (Relationship)

Date

*No alterations to this form will be deemed valid. Please see the Notice of Privacy Practices, if you would like us to consider any special requests.