MINNESOTA ONCOLOGY

Patient Consent

Release of information by Minnesota Oncology & Hematology, P.A. In order to assure proper quality and continuity of care, I consent to the release by Minnesota Oncology Hematology, P.A. (the "Clinic") of my health records and medical information about me (including information, if any, about substance abuse, mental health, HIV/AIDS, or other health issues) to physicians, providers, and staff as necessary for treatment, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including release for purposes of internal and external audits, research and quality assurance, accreditation, or insurance.

I give permission to the Clinic to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.

Release and Exchange of Health Information for Third-Party Payor and Healthcare Operations: I give permission to my third-party payer to share my past, current and future health and account records with the Clinic about services I've received from the Clinic and other care providers unrelated to the Clinic (provided that no further health records shall be shared upon the revocation of this consent). These records may be used by the Clinic as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will check here: ☐

Release of Health Information for Treatment: I authorize the Clinic, affiliates, and agents of the Clinic, to release my health records, and other information related to my health care, to other health care providers for use in treatment, including coordinating my care. This consent does NOT include release of information obtained by or created in a drug or alcohol abuse treatment unit.

Provider Record Locator or Patient Information Service: A health record locator service or patient information service helps my health care providers determine where I have received care and obtain information about my health to help treat me. The Clinic, may use or view my information in a record locator service or patient information service to help provide care to me, unless I check here: ☐

Voicemail, Text Messages and Email: I authorize MN Oncology to use and disclose medical information to contact me regarding an appointment/appointment reminder, possible treatment options or other benefits or services that may be of interest to me. MN Oncology may: call me and, if necessary, leave messages, send me text messages and email me. If I do not agree to this, I will check here: ☐

Duration of consent:
I understand this Consent to Release of Information does not expire unless I revoke it in writing.

Patient Consent

BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES DESCRIBED ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF CLINIC'S NOTICE OF PRIVACY PRACTICES.

Patient First & Last Name (Please print)	Date
Patient Signature	**Patient Date of Birth**
Name of legal representative, if appropriate	**If legal representative, relationship to patient**

Notice of Privacy Practices Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Clinic Notice of Privacy Practices. The Clinic is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Clinic Use Only:

I, _____, attempted to obtain the patient's acknowledgement of the receipt of the Notice of Privacy Practices, but was unable to do so.	
Reason acknowledgement not obtained:	
iKM Release of Information updated ☐	
Signature:	Date: