

## Consent to Arrange for Payment and for Sharing of My Information



CAUTH

*Your privacy is important. If you don't understand this form, ask questions. If you'd like us to consider any special requests, please refer to the Notice of Privacy Practices for contact information. We cannot accept changes to this form.*

### My consent to sharing (release) of my information

- **For treatment:** I authorize you, as my provider, to share my information with other healthcare professionals and facilities for treatment purposes, such as managing or coordinating my care, and related services.
- **For payment:** I authorize you, as my provider, to share my information with my health plan and others as needed for payment purposes, such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, utilization review, and related functions, including those functions that you, as my provider, are required by my health plan or other third-party payers to perform.
- **To run your organization (health care operations):** I authorize you, as my provider, to share my information with others to improve the quality of my care and experience, and to manage your business operations. This includes activities such as licensing and accreditation, and evaluating quality.
- **Health plan information:** I authorize my health plans to share my information (about services I have received) with you, as my provider, and with other professionals and facilities from whom I receive healthcare, as needed for treatment, management and coordination of my care, accreditation and quality review/measurement.
- **Health plan release of information:** My health plans may share my claims data with you, as my provider, about services I have received from you and other caregivers outside of this organization. This does not include written medical records. This data will assist in the coordination of my care with all of my caregivers, inside and outside of this organization.  
 I do NOT want claims data shared by my health plan (valid if my health plan allows me to opt out of this sharing).

### My responsibility for payment and assignment of benefits

- I authorize you, as my provider, to bill my health plans (including Medicare/Medicaid and other third party payers), directly on my behalf, so that you will receive direct payment of authorized benefits.
- I agree that it is my responsibility to pay for any items or services not covered by my health plans, such as co-payments, deductibles or co-insurance.

## My consent to share my information with external health researchers

Research leads to new and better ways to understand and treat diseases and improve care. Our organization often works with outside health researchers. Any health research involving my information is required to get prior review and approval from an Institutional Review Board (IRB). The IRB is charged with the protection of research subjects and helps ensure research is conducted responsibly. Any published results will not identify specific patients.

Unless I check the box below, I authorize the sharing of my information with external health researchers in accordance with the law.

I do NOT want to have my information shared with external health researchers.

## My signature and acknowledgment

My consent will be valid for ten years from the date I give it. I may revoke my consent to share my information, in writing, at any time. Revoking my consent doesn't apply to information that has already been shared. I understand that some uses and sharing of my information are authorized by law and do not require my consent.

For the purposes of my consent, "provider" means the organizations that are part of HealthPartners (see the list in the Notice of Privacy Practices), and use of my information within this group is permitted and is not a "release" of my information. "My information" means information that identifies me and relates to my health and services received, as explained in more detail in the Notice of Privacy Practices.

My provider's Notice of Privacy Practices has been made available to me. It describes my privacy rights and additional disclosures my provider may make according to law.

Date	Time	Signature of patient/authorized representative <b>X</b>
Patient date of birth		Print name
If authorized representative, relationship to patient		Reason patient unable to sign