RELEASE OF MEDICAL RECORDS

Minnesota Lung Center/Minnesota Sleep Institute

Assignment of Benefits and Release of Information. I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by my health care provider, including physician services, or by any provider under contract with my health care provider or participating in a provider network in which my health care provider or its affiliates participate. I consent to the release of my health records and other information related to my health care services for payment and health care operations purposes. I agree that my health records and other information may be released to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties.

Release of Information by Payers and Networks. I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations. **I understand that I am financially responsible for any balance:**

Patient Name (Please Print) Date of Birth Today's Date

Patient/Guardian Signature

Emergency Contact Phone Relationship

WORKER'S COMPENSATION / AUTO ACCIDENT

Date of Injury: _____ Insurance Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Claim/File Number: _____ Contact Person: _____

SKILLED NURSING FACILITY / HOSPICE

Is the patient currently a resident in a skilled nursing facility or hospice? ☐Yes ☐No

If Yes, please provide name and address of facility.

Facility Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone : _____