

Minnesota Epilepsy Group, P.A.[®]

225 Smith Avenue North, Suite 201, St. Paul, MN 55102 Phone: (651) 241-5290 Fax: (651) 241-5248

Consent and Authorization for Release of Information

Release of Information I consent to the use, release, and exchange of my protected health information between Minnesota Epilepsy Group, P.A. (MEG) and others involved in my care to the extent permitted by law including the following:

- To/from a health care provider, school, group home, nursing home, social worker, or other care provider being advised or consulted in connection with my treatment or care;
- To/from a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
- To/from a person or organization in connection with MEG's health care operations. Operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.

Consent for Research. I consent to the use of information in my Minnesota Epilepsy Group medical record for scientific research purposes. I understand that my name or other identifying information will not be used and my identity will remain anonymous.

Revocation. I understand I may revoke this consent at any time by giving written notice to MEG.

Blood Tests. If a person furnishing services on behalf of MEG is at any time exposed to my blood or bodily fluids through a needle stick or otherwise, I agree to submit to a blood test for blood-borne diseases, including hepatitis and HIV (the virus that causes AIDS). MEG will furnish me with the results of the blood test and offer consultation services upon my request.

Payment Authorization

Payment Responsibility I acknowledge that I am responsible to pay for all services furnished to me by MEG, including, but not limited to, charges that are not paid in full by my insurance, government program benefits, or other third-party payors, except as prohibited by MEG's contract with my health plan or applicable law. I further agree to pay or reimburse MEG for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees.

Payment Authorization I authorize MEG to directly bill my health plan or third-party payor for services rendered to me by or on behalf of MEG, but acknowledge that MEG is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to MEG for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to MEG directly on my behalf by my Medigap insurer. I understand and agree that MEG is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

Statement to Permit Payment for Medicare Benefits to MEG If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to MEG, for any services furnished to me by or in MEG, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Notice of Privacy Practices

Confidentiality It is the policy of MEG to protect the privacy and confidentiality of patient health information.

Notice of Privacy Practice Attached hereto is MEG's Notice of Privacy Practices which explains how MEG may use and disclose my health information. It also explains my rights regarding this kind of information.

Acknowledgment of Receipt _____ I acknowledge that I have received MEG's Notice of Privacy Practices.
Please Initial Here

Patient's Name (please print): _____ Date of Birth: ____/____/____

Signature of Patient (if applicable): _____ Date: ____/____/____
* must be renewed one year from this date

Name of Legal Guardian (if applicable) (please print): _____

Signature of Legal Guardian: _____ Date: ____/____/____