

MINNEAPOLIS RADIATION ONCOLOGY, P.A.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

RE: _____ BIRTHDATE _____

I authorize _____ to release to

(Name of Facility)

Name of Clinic

Address of clinic

Information from the medical records acquired while I was a patient during _____ (Date)

This information is to be used for consultation and the feasibility and effectiveness of radiation therapy as it relates to my condition. Protected Health information will not be re-released.

The information to be disclosed is:

_____ Discharge summary

_____ Consultation

_____ History and Physical

_____ Operative Report

_____ Progress notes

_____ Lab reports _____

_____ Radiology films/scans

_____ Radiology reports

_____ Pathology reports

_____ Other _____

I understand that this authorization is voluntary. Authorization is valid for one year. I understand I may revoke this authorization by signing an authorization revocation statement. I understand that I may see the information described on this form if I ask for it.

Date

Print Patient Name

Signature or Legal Representative

Legal Relationship

10/02

Manual/ Authorization Protected health information

SUMMARY OF NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 4/14/03

We at Minneapolis Radiation Oncology, P.A. recognize that our relationship with you is based on integrity and trust. We work hard to maintain your privacy. Protected health information is any clinical, social, financial or other personal data.

1. Protected health information will be released, with your permission, to any health care provider involved with your care for continuity of care.
2. Protected health care information will be released, with your permission, to your insurance companies for claims processing, quality of care review and studies.
3. We require anyone to whom we disclose your protected health information to protect its confidentiality and to use it for the purpose for which it is disclosed.
4. We restrict access of protected health care information to employees involved in your care.
5. We maintain physical, electronic and procedural safeguards with applicable regulatory standards to guard your protected health information.
6. You have the right to look at or get a copy of health information about you.
If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.
7. If required by law, we will release your protected health information without your consent.
8. We are required by law to protect the privacy of your information, provide a notice about our information practices and follow practices that are described in the Notice of Privacy Practices. The complete Notice of Privacy Practices may be obtained from the Medical Secretary.
9. We may change our Privacy Practices at any time. If we change our notice, the new Notice of Privacy Practices will be available from the Medical Secretary. A new Summary of Notice of Privacy Practices will be posted in the waiting area and in each examination room.
10. If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint, contact the Clinic Supervisor, Chief Therapist who will help you contact our Compliance Nurse. You also have the right to file a complaint with the Secretary of the United States Department of Health and Human Services.