Allina Hospitals & Clinics
CONSENT for RELEASE OF INFORMATION

1. Provider Record Locator: A health record locator service helps my health care providers determine where I have received care and obtain information about my health to help treat me. Allina Hospitals & Clinics ("Allina") may access my information in a record locator service to help provide care to me. Allina may share my health record and information with a health record locator service unless I check in the box below. If I check the box below, I understand Allina will exclude my information from any record locator services. □

2. Release of Information to Payers: I consent to the release of my health records and other information related to my health care services for payment and healthcare 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.

3. 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 Allina or any other provider, with Allina, 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.

4. Release of Information to Health Care Providers. I consent to the release of my health records created, received and maintained by Allina for my treatment to other health care providers who are involved in my treatment. This consent does NOT include release of information obtained by or created in a drug or alcohol abuse treatment unit.

5. Consent for Use of Medical Records in Research. I authorize Allina Hospitals & Clinics to use or disclose my medical records for research, including health records created by Allina and those records Allina receives from other health care providers while treating me unless I check here. □

This consent will continue forever unless you cancel it by writing us at: Allina Health Information Management, Mail Route 20300, 800 East 28th Street, Minneapolis, MN 55407; but if the consent is cancelled, it will not change releases that have already been made.

Student's Printed Name	Student's Date of Birth (mm/dd/yyyy)
Legal Representative Printed Name	Parent of student Authority to sign for patient
Legal Representative Signature	Date (mm/dd/yyyy)

ALLINA HOSPITALS AND CLINICS

Consent for Release and Combining of Health Records Among Health Care Providers

Several other health care providers in the area, including our organization use the same Excellian electronic medical record system to document and review the health care services they provide to you. Use of the Excellian electronic medical record allows your providers to coordinate your care, improve exchange of important information about your treatment, get complete and up-to-date information to any provider who uses Excellian.

A list of the healthcare provider organizations that currently use the Excellian electronic medical records system has been given for you to review with this consent. In the future, more health care providers may join in using this same electronic medical record system. This consent applies to your providers who use the system now and in the future. You can review an up to date list of the providers who use this record system any time you come to Allina Hospitals and Clinics for a visit or by going to our website at www.Allina.com/medical records for more information.

Your health information will be stored, viewed and shared by your health care providers in a secure electronic medical record system. When you are treated by any of the health care providers on this list, each provider will use the same electronic medical record to document information about your treatment. All of the information about your treatment with these providers will be combined into one electronic medical record that will be shared by all of them for your treatment. Once your information is combined, it cannot be separated.

I authorize any health care provider who uses the Excellian electronic medical record system to share the health records my providers create or receive related to my treatment, with other health care providers who treat me. My providers may share this information with each other as needed to provide my treatment and carry out services and operations related to my treatment. I understand that this information will be shared primarily through a combined electronic medical record where all of the health care providers who use Excellian and provide treatment to me will document my care and services.

This consent applies to health records that my health care providers already have about me, and information about future care I may receive from them. This consent will continue forever unless I cancel it by giving written notice to: Allina Health Information Management, Mail Route 20300, 800 East 28th Street, Minneapolis, MN 55407. If I cancel the consent, it will apply to information *created after the date* when the notice to cancel is received. It will not affect information that has already been shared among my health care providers or combined based on this consent.

I authorize my health care providers to share my records as described in this consent.

Student's Printed Name	Student's Date of Birth (mm/dd/yyyy)
Legal Representative Printed Name	Parent of student Authority to sign for patient
Legal Representative Signature	Date (mm/dd/yyyy)

Allina Hospitals & Clinics
ASSIGNMENT OF BENEFITS FORM

Assignment of Benefits: 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 Allina, including physician services, or by any provider under contract with Allina or participating in a provider network in which Allina or its affiliates participate.

Important Information for Patients.

Initial here to indicate receipt of information: _____ Notice of Privacy Practices

Student's Printed Name	Student's Date of Birth (mm/dd/yyyy)
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Legal Representative Signature	Date (mm/dd/yyyy)

Guarantee and Agreement to Pay

NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below.

I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that 6% interest per year may be added if the account balance goes to a collection agency.

Student's Printed Name	Student's Date of Birth (mm/dd/yyyy)
Legal Representative Printed Name	Parent of student Authority to sign for patient
Legal Representative Signature	Date (mm/dd/yyyy)