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

Important Information for Patients. I received the material on each line initialed below.

_____ Notice of Privacy Practices (unless received during previous visit)
_____ Federal and State Patient Rights Information
_____ Health Care Directive Brochure
_____ Important Message from Tricare/Champus (inpatient visit only)

_____ _____
Signature of Patient, or if Patient is unable to sign, a Representative of the Patient — Date/Time

_____ _____
Relationship to Patient (if patient is unable to sign) — Reason Patient Unable to Sign

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.

_____ _____
Patient, Legal Representative or Guarantor Signature — Date/Time

☐ **Directed by Patient to sign on their behalf (having read this document to them)**

Allina Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-506-4595.

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-506-4595.

ALLINA HEALTH
CONSENT FOR USE AND RELEASE OF HEALTH INFORMATION

This consent applies to all Allina Health locations where I may receive my care.

Treatment, Payment and Operations: I authorize Allina Health, any other health care providers, entities that pay for my health care, and anyone affiliated with or authorized by them to: release and receive my health records and other information about my health care for treatment, payment and health care operations purposes as described in Allina Health's Notice of Privacy Practices. I understand that information received by or created in a drug or alcohol abuse treatment unit may require another authorization before it can be released for some or all of these purposes.

Provider Record Locator or Patient Information Service: A health record locator or patient information service helps my health care providers know where I have received care and get information about my health to help treat me. Allina Health and other providers who participate in a record locator or patient information service may access my information in a record locator or patient information service to help provide care and services to me. Allina Health may share my identifying information and location of my health records with a health record locator or patient information service, unless I check here: ☐

Consent for Use and Disclosure of Medical Records in Research: I authorize Allina Health to use or disclose my medical records for research. This includes health records created by Allina Health and any records Allina Health receives from other health care providers while treating me, unless I check here: ☐

This consent will continue forever unless I cancel it in writing at: Allina Health Information Management, Mail Route 20300, 2828 10th Ave. S., Minneapolis, MN 55407. If I cancel my consent, it will not change releases that have already been made.

Patient or Legal Representative Signature	Date/Time
Legal Representative Printed Name (if signing for patient)	Authority to sign for patient (Attach Documentation)

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