PARKVIEW MEDICAL CLINIC
1400 1ST St NE
PO Box 186
New Prague, MN 56071
PH: 952-758-2535
FAX: 952-758-6101

John H. Berg Jr., MD
Daniel R. Berg, MD
Michael P. O'Rourke, MD
Jean E. Craig, MD
Heather R. Hamernick, MD

Release of Information & Payment Authorization

Records Release: I hereby authorize the release of any information, including medical and billing information, by Parkview Medical Clinic to my referring doctor, insurance company, the responsible party named on my account, and immediate family on behalf of myself and/or dependents.

Date:____________________________ **Signed X**____________________________

I understand and agree that my insurance company my share my past, current and future health and account records with Parkview Medical Clinic regarding services I have received from Parkview Medical Clinic and other care providers unrelated to Parkview Medical Clinic. These records may be used by Parkview Medical Clinic as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

____My insurance company may not release any identifiable health information from providers unrelated to Parkview Medical Clinic for purposes described above.

Assignment of Benefits: I hereby authorize payment of medical benefits from any insurance coverage or employee flex plans to be assigned & paid directly to **Parkview Medical Clinic** for services rendered to myself and/or dependents.

Date:____________________________ **Signed X**____________________________

Medicare Authorization: I request that payment of authorized Medicare benefits on my behalf, be paid directly to Parkview Medical Clinic for any services rendered me by that clinic or its physicians. This authorization includes payments from any Medicare supplement coverage I may have.

I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in the place of the original.

I understand that I am financially responsible for any charges not covered by Medicare. This may include injections, throat culture, lab work and items considered "not medically necessary" by Medicare.

Date:____________________________ **Signed X**____________________________