DOCTORS© PAIN CLINIC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent the practice may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the NOTICE OF PRIVACY PRACTICES for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. (The practice reserves the right to revise its Notice of Privacy Practices at anytime.)

With my consent the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent the practice may release information to (spouse, family member, other)

_____. *Please print name and relationship.*

With my consent the practice may mail to my home or to other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that the practice limit and or restrict how it uses or discloses my PHI to carry out TPO. However, I have been informed the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**** *A request for limitations and restrictions of PHI form must be submitted.*****

By signing this form, I am consenting to the practice use and disclosure of my PHI to carry our TPO. I am also acknowledging that no recording devices will be used on the premises in order to protect any PHI throughout the Doctors Pain Clinic.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES.

_____

Signature of Patient *or* Legal Guardian (relationship) Date _____

_____

Print Name of Patient *or* Legal Guardian (relationship)

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