PRIVACY POLICY

Patient Consent for Use and Disclosure of Protected Health Information

Edina • Maple Grove • Woodbury
Twin Cities Pain Clinic

I hereby give my consent for TWIN CITIES PAIN CLINIC ("Clinic") to use and disclose protected health information (PHI) for performing any activity for **treatment**: providing, coordinating, and managing quality patient care; **payment:** ensuring that the practice gets paid for services; and **operations of the practice:** internal management activities. This is also referred to as TPO.

Clinic's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have reviewed the Notice of Privacy Practices prior to signing this consent.

With this consent:

1. Clinic may call my home or other alternative location and leave a message on the recorder or in person in reference to any items that assist the practice in carrying out TPO, such as insurance items and my clinical care including laboratory results.
2. Clinic may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as patient statements.
3. I authorize the following person(s) to be my personal representative, which means the doctor and staff may speak freely to the named representative regarding all my PHI, Medical and Treatment matters and Billing:

Name	**Relationship**

I have the right to request that Clinic restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I was notified of the Privacy Practices and am consenting Clinic's use and disclosure of my protected health information to carry out treatment, payment, and operations. Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Twin Cities Pain Clinic at 7235 Ohms Lane, Edina, MN 55439

_____ Date_____
Patient Signature

_____ Date of Birth_____
Patient Printed Name

TCPC OFFICE USE ONLY	Patient was given Notice of Privacy Practices and refused to sign this consent on DATE_____ EMPLOYEE INITIALS _____