Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Murphy Pain Center (MPC) and its representatives to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Murphy Pain Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Administrator, Murphy Pain Center, 720 Rolling Creek Drive, Suite 101, New Albany, IN 47150.

With this consent, MPC may mail me, email me, fax me, telephone me, text message me, FaceTime me, or use other electronic media (such as Zoom) and, if necessary, may leave a message on voice mail or may leave a message with another person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that MPC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions. By signing this form, I am consenting to allow MPC to use and disclose my PHI to carry out TPO. 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, or later revoke it, MPC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name (Print Name of Legal Guardian, *if applicable*)

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Consent to Release of Information Under 42 C.F.R. Part 2

I authorize Murphy Pain Center (MPC) and its representatives to disclose my drug or alcohol treatment information as protected by SAMHSA confidentiality regulation Title 42, Part 2 of the Code of Federal Regulations (42 C.F.R. Part 2) to any individual or entity in order to carry out treatment, payment and health care operations (TPO) on my behalf. I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically upon termination of my treatment by MPC.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name (Print Name of Legal Guardian, *if applicable*)