PRIVACY CONSENT for Purposes of Treatment, Payment and Health Care Operations

Name (please print) _____

I consent to the use or disclosure of my protected health information by Murphy Pain Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care services or to carry out the Practice's healthcare operations.

I understand that Murphy Pain Center may condition its diagnosis or treatment of me upon my consent to allow its use or disclosure of my protected health information.

I acknowledge Murphy Pain Center has provided me a copy of its Notice of Privacy Practices, which provides a more detailed description of the uses and disclosures allowed by this consent. I acknowledge my right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to change the privacy practices outlined in the Notice of Privacy Practices. I may obtain a revised copy by asking for one at the time of my next appointment.

I understand that I have the right to request restriction on how the Practice uses and disclosures of my protected health information for treatment, payment, or the health care operations. Murphy Pain Center is not required to agree to any restriction, but if it does, the restriction is binding.

I have the right to revoke this consent in writing, except to the extend Murphy Pain Center has taken actions in reliance on this consent.

I authorize Murphy Pain Center to **disclose personal information about me to the following person(s)**. Information disclosed may include, but not exclusive: account balance, billing information, appointments, treatment, plan of care, and prescriptions. This authorization expires upon my death, unless revoked by me in writing.

→ _____ _____
Person **Relationship to Patient**

→ _____ _____
Person **Relationship to Patient**

→ _____ _____
Person **Relationship to Patient**

X_____ _____
PATIENT or Personal Representative SIGNATURE Date

_____ _____
Witness Date