PRIVACY POLICY

Patient Consent for Use and Disclosure of Protected Health Information

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 any other alternative location, any items that assist the practice in carrying out TPO, such as patient statements.
3. Clinic may send me text messages and/or emails for the purpose of carrying out TPO, including messages related to appointment management, continuity of care, announcements, and obtaining feedback. I understand that Clinic may share my information with an authorized third-party for the sole purpose of sending me messages related to TPO, and that Clinic will never sell my information to a third party. I acknowledge that message frequency may vary, and that I may opt out of these messages anytime. ***DISCLOSURE: Message and data rates may apply.***
4. I acknowledge that Dr. Andrew Will has ownership interest in Twin Cities Pain Clinic, Twin Cities Surgery Center, Burnsville Surgery Center, Twin Cities Anesthesia, and Twin Cities Pain Clinic Transportation, and I consent to the sharing of my personal health information between these entities for the purpose of continuity of care.
5. I authorize the following person(s) to be my personal representative(s), which means the doctor andstaff may speak freely to the named representative(s) 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 to Clinic's use and disclosureof my protected health information to carry out treatment, payment, and operations. Clinic 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 Twin Cities Pain Clinic at 7235 Ohms Lane, Edina, MN 55439.

Federal law permits Twin Cities Pain Clinic to use and disclose medical information about you for research purposes, either with your specific, written authorization or when the study has been reviewed for privacy protection by an Institutional Review Board or Privacy Board before the research begins. In some cases, researchers may be permitted to use information in a limited way to determine whether the study or the potential participants are appropriate. Minnesota law generally requires that we get your consent before we disclose your health information to an outside researcher. We will make a good faith effort to obtain your consent or refusal to participate in any research study, as required by law, prior to releasing any identifiable information about you to outside researchers. (Minn. Stat. § 144.295 subd.1)

Patient Signature	Date
Patient Printed Name	Date of Birth

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