NURSES FOR SAFE ACCESS
A COLLECTIVE OF CARING NURSES

Patient Consent Form

Use of this form is optional and not required under the HIPAA privacy rule.

Nurse Advocate:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for _____to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Cannabis treatment modalities maybe utilize and I give my full consent knowing that cannabis is still considered a: **SCHEDULE I CONTROLLED SUBSTANCE. KEEP OUT OF REACH OF CHILDREN AND ANIMALS. CANNABIS PRODUCTS MAY ONLY BE POSSESSED OR CONSUMED BY PERSONS 21 YEARS OF AGE OR OLDER UNLESS THE PERSON IS A QUALIFIED PATIENT. THE INTOXICATING EFFECTS OF CANNABIS PRODUCTS MAY BE DELAYED UP TO TWO HOURS. CANNABIS USE WHILE PREGNANT OR BREASTFEEDING MAY BE HARMFUL. CONSUMPTION OF CANNABIS PRODUCTS IMPAIRS YOUR ABILITY TO DRIVE AND OPERATE MACHINERY. PLEASE USE EXTREME CAUTION WITH ALL OF YOUR ACTIVITIES OF DAILY LIVING!**

(The Notice of Privacy Practices provided by _____ describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. _____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 _____.

With this consent, _____may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent,_____ may mail to my home or other alternative 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."

With this consent, _____may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that _____restrict how it uses or discloses my PHI to carry out TPO. 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 am consenting to allow _____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, _____may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

_____
Nurse-Advocate Signature