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COLUMBUS
CANNABIS
CONSULTANTS

PATIENT ACKNOWLEDGMENT FORM
NOTICE OF PRIVACY PRACTICES AND CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Columbus Medical Consultants, LLC dba Columbus Cannabis Consultants Privacy Practices.

CONSENT OF HEALTH INFORMATION: This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to *Columbus Cannabis Consultants* to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care with this practice.

CONSENT FOR TREATMENT: I, with my signature, authorize this practice and any employee working under the direction of the physician, to provide medical care for me, or to this patient which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

CONSENT RELATED TO THE PRIVACY NOTICE: I have had a chance to review the Privacy Practice Notice as part of this registration process. I understand that the terms of the Privacy Practice Notice may change and I may obtain these revisions by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on the use, it is bound by that agreement.

If we are unable to reach you personally, do we have your permission to leave a message on your voicemail or answering machine? (Initial here for YES) _____ Phone#_____

I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING:

1. _____RELATIONSHIP_____PHONE #_____
2. _____RELATIONSHIP_____PHONE #_____
3. _____RELATIONSHIP_____PHONE #_____

PATIENT PRINTED NAME _____

PATIENT SIGNATURE _____DATE_____

PATIENT'S PERSONAL REPRESENTATIVE _____DATE_____

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