



Anodyne Inc.
6024 Blue Circle Drive
Minnetonka, MN 55343

Telephone: 952-546-5334
Fax: 952-546-2657

Anodyne, Inc has a legal obligation to maintain the privacy of our client’s confidential health care information, known as Protected Health Information, and to provide you with a notice of our legal duties and practices with respect to your protected health information. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used and disclosed for treatment, payment or health care operations. We may call or write to remind you of scheduled appointments, to notify you of other products available at our office that might help you. Unless you advise us otherwise, we may mail you a bill or invoice, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home regarding services with Anodyne.

Listed below are the individuals I wish to grant access to my medical and/or financial information. I understand that the information is limited to verbal discussion only and that no paper copies of my protected health information will be provided without my written consent on a Release of Information and Assignment of Benefits form.

Name	Relationship
_____	_____
_____	_____
_____	_____

Please review our Notice of Privacy Practices carefully. Please sign below acknowledging you have received this notice and return the signed letter to:

ANODYNE
6024 Blue Circle Drive
Minnetonka, MN 55343

Sincerely;
Anodyne, Inc.

By signing this form, I consent to Anodyne’s use and disclosure of protected health information for their treatment, payment, and health care operations. I hereby authorize Anodyne to release to my referring physician and insurance company information including diagnosis and records or treatment concerning my medical history and care. This consent will be considered valid until such time that I revoke it. I acknowledge that I received a copy of the Notice of Privacy Practices.

**Patient Name/
Responsible Party Name:** _____ **DOB** _____
Please Print

**Patient Signature/
Responsible Party Signature:** _____ **Date:** _____
Signature