

## Maryland Brain, Spine & Pain

I hereby give me consent for Maryland Brain, Spine, and Pain to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Maryland Brain, Spine, and Pain describes such uses and disclosures more completely)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Maryland Brain, Spine & Pain 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 Stevan Flury, Administrative and Privacy Officer.

With this consent, Maryland Brain Spine, and Pain may call my home, cell, or other alternative location and leave a message on voicemail 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, Maryland Brain Spine, and Pain 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". I have the right to request that Maryland Brain Spine, and Pain 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 Maryland Brain Spine, and Pain to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the practice has already made disclosures in the reliance upon my prior consent.

---

Signature of Patient or Legal Guardian

---

Print Patients Name

---

Date

---

Print Name of Legal Guardian, if applicable