

**HOUSTON NEUROLOGY ASSOCIATES
PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby give my consent for Houston Neurology Associates to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. (Houston Neurology Associates Notice of Privacy Practices provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Houston Neurology Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Houston Neurology Associates at 7500 Beechnut, Suite 135, Houston, TX 77074.

With this consent, Houston Neurology Associates 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 treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Houston Neurology Associates may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

With this consent, Houston Neurology Associates may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Houston Neurology Associates restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

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 am consenting to Houston Neurology Associates use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

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, Houston Neurology Associates may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name (printed)

Date