

TOWSON NEUROLOGY ASSOCIATES, PA

Patient Consent for Use and Disclosure of Protected Health Information

With this consent, Towson Neurology Associates, PA may call or email to 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 (TPO), such as appointment reminders (via the automated call service or appointment reminder cards), patient statements, insurance items and any calls pertaining to my clinical care including laboratory test results. I have the right to request restrictions on how my protected health information is used and disclosed 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. 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 Towson Neurology Associates, PA may decline to provide treatment to me. I have the right to review the Notice of Privacy Practices. Towson Neurology Associates, PA reserves the right to revise its notice at any time.

**Please check all the ways we may contact you**

Print Name of Patient: \_\_\_\_\_

Home: Yes \_\_\_ No \_\_\_ Phone # \_\_\_\_\_ Leave a message: Yes \_\_\_ No \_\_\_

Work: Yes \_\_\_ No \_\_\_ Phone # \_\_\_\_\_ Leave a message: Yes \_\_\_ No \_\_\_

Cell: Yes \_\_\_ No \_\_\_ Phone # \_\_\_\_\_ Leave a message: Yes \_\_\_ No \_\_\_

Mail from Towson Neurology Associates, PA: \_\_\_ use a return address envelope \_\_\_ use a plain envelope

Email: Yes \_\_\_ No \_\_\_ If yes, email address: \_\_\_\_\_

You may discuss or leave a message regarding my health care with:

_____	_____	_____
Name of person	Phone number	Relationship to patient

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_