

LANCE E. GRAVELY,
NEUROLOGICAL SURGERY

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Lance E. Gravely, M.D., Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Lance E. Gravely, M.D., Inc's notice of privacy practices provides a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Lance E. Gravely, M.D., Inc 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:

Lance E. Gravely, M.D., Inc
Privacy Officer
1700 Cesar Chavez Avenue, Suite 3750
Los Angeles, Ca 90033

With this consent, Lance E. Gravely, M.D., Inc. 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 TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Lance E. Gravely, M.D., Inc. may mail to my home or other alternative location for 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 Lance E. Gravely, M.D., Inc restrict how it uses or discloses my PHI to carry out TPO. 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 Lance E. Gravely, M.D., Inc's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent, or later revoke it, Lance E. Gravely, M.D., Inc. may decline to provide treatment to me.

I have been furnished and have read the Notice of Privacy Practices.

Signature of Patient/or Legal Guardian_____

Patients Name_____

Date_____

Print Name of Patient or Legal Guardian_____