PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

BRANDYWINE MEDICAL ASSOCIATES

With my consent, BRANDYWINE MEDICAL ASSOCIATES, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to BRANDYWINE MEDICAL ASSOCIATES's Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, BRANDYWINE MEDICAL ASSOCIATES may disclose my PHI to the following individuals (family, relatives or friends) who may assist in my care: _____

(Please indicate name of individuals to whom BRANDYWINE MEDICAL ASSOCIATES may release PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent. BRANDYWINE MEDICAL 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 BRANDYWINE MEDICAL ASSOCIATES's Privacy Officer at 161 Becks Woods Drive, Bear, DE 19701.

CONSENT FOR CALLS TO HOME

With my consent, BRANDYWINE MEDICAL ASSOCIATES may call my home or other designated location and leave message on my voice mail or in person in reference to any item that may assist BRANDYWINE MEDICAL ASSOCIATES in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL

With my consent, BRANDYWINE MEDICAL ASSOCIATES may mail to my home or other designated location any item that may assist

BRANDYWINE MEDICAL ASSOCIATES in carrying out TPO, such as appointment reminder cards and patient statement as long as they are marked PERSONAL AND CONFIDENTIAL.

CONSENT FOR E-MAIL ADVICES

With my consent, BRANDYWINE MEDICAL ASSOCIATES may e-mail to my designated e-mail address any message in reference to any item that may assist

BRANDYWINE MEDICAL ASSOCIATES in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that BRANDYWINE MEDICAL ASSOCIATES restrict how it uses or discloses my PHI to carry out the TPO, However,

BRANDYWINE MEDICAL ASSOCIATES 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 BRANDYWINE MEDICAL ASSOCIATES's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that BRANDYWINE MEDICAL ASSOCIATES has already made disclosure in reliance upon my prior consent. If I do not sign this consent, BRANDYWINE MEDICAL ASSOCIATES may decline to provide treatment to me.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Print Name of Patient or Legal Guardian

(PATIENT /GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION)