Nevro Corp. • 1800 Bridge Parkway • Redwood City, CA 94065 USA • 650.251.0005

Patient Authorization Form for Release of Information

INFORMATION AUTHORIZED TO BE DISCLOSED. I hereby authorize my health care providers and health plan(s) to release and disclose, in electronic or other form, my protected health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information) to Nevro Corp. ("Nevro") and my treating pain specialist including, without limitation my personal contact information; and all medical records and related information with respect to my treatment, my eligibility for assistance, and the coordination or receipt of treatment, including:

- CPT/HCPCS/diagnosis codes; insurance information; appointment(s) scheduled;
- psychiatric evaluations;
- medical history in support of coverage for spinal cord stimulation ("SCS"); and
- treatment records in support of insurance claim appeal or workers compensation or if needed (collectively, my "Information").

PURPOSE(S) OF DISCLOSURE. I authorize the disclosure of my information, whether provided to Nevro before or subsequent to my completion of this authorization, for purposes of:

- establishing my benefit eligibility for Nevro products, including through benefits investigation, prior authorization support, insurance claims appeals support, or workers compensation case review;
- designating Nevro (including its employees and Business Associates) to act as my appointed Authorized Representative to assist me with appealing my spinal cord stimulation (SCS) insurance denial, if prior authorization is not approved;
- communicating with my health care providers and health plans about my medical history and support through HFX Access™, my benefit and coverage status, and/or my medical care;
- providing other HFX Access support, information about a Nevro product and related patient support or analyzing insurance coverage or reimbursement patterns or the effectiveness of Nevro products or services; and
- reporting safety information, including to the U.S. Food and Drug Administration.

ACKNOWLEDGEMENTS. Hospitals, medical clinics, health plans and individual providers, such as physicians, may be subject to HIPAA or other privacy laws and are required by law to keep your Information confidential. If you have authorized the disclosure of your Information to someone who is not subject to HIPAA or other privacy laws or is not legally required to keep it confidential, then your Information may no longer be protected by state or federal confidentiality laws and re-disclosure may be permitted under federal and state privacy laws.

YOUR RIGHTS. This Authorization to release your Information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization, except in the following cases: (1) to obtain reimbursement support by Nevro for patients seeking SCS treatment, including conducting a benefits investigation or obtaining prior authorization for treatment with your insurance provider; (2) to create health information to provide to a third party; or (3) to conduct research-related treatment. You are entitled to receive a copy of this Authorization.

TERM. This Authorization will expire two years from the date of execution unless revoked earlier in writing. This Authorization remains in full force and effect until such expiration, and further authorizes my providers and health plan(s) to release any additional records created or obtained by my providers and health plan(s) after the date hereof.

REVOCATION. This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your representative, and delivered to: Privacy Officer, Nevro Corp., 1800 Bridge Parkway, Redwood City, CA 94065. Any revocation is effective only after it is received and logged in by the Nevro Privacy Officer, thus any use or disclosure of my Information which is made pursuant to this Authorization prior to the revocation will not be affected.

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HFX Access. Please note that the following are required before HFX Access support can be initiated: (1) this executed and validated Authorization from patient/representative; and (2) a completed intake form and requested medical information from the referring health care provider(s). You may return this completed Authorization to your physician, via HFXAccess@nevro.com or by facsimile to 650.252.1400. If you have any questions, please contact the HFX Access Team at 650.251.0005.

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

Where do you want this information sent?

Recipient Names: Nevro HFX Access Team Pain Specialist (if known):	Nevro Secure Fax: 650.252.1400 Nevro Secure Email: HFXAccess@nevro.com

Signature of Patient or Legal Representative*	**Date**
Sign and Date here	
Relationship of signatory to the patient: ☐Self ☐Representative	
Note: If a personal representative executes this form, that representative warrants that he/she/they has/have authority to sign this form based on the following:	

Authorization to Receive Additional Information

I consent to Nevro Corp. ("Nevro") contacting me regarding HFX Access support via the following:

☐ Mail ☐ Phone ☐ Text at: _____ ☐ E-mail Which is preferred? _____

Signature of Patient or Legal Representative*	**Date**
Sign and Date here	
Relationship of signatory to the patient: ☐Self ☐Representative	
Note: If a personal representative executes this form, that representative warrants that he/she/they has/have authority to sign this form based on the following:	