

**Excellent Vision, LLC.**  
**Authorization to Use and Disclose Protected Health Information**

Patient _____		
Name: Last	First	Middle
Address: _____	City: _____	State: _____ Zip: _____
Home#: _____	Birth Date: _____	

With my consent, Excellent Vision, LLC. May use and disclose protected health information about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Excellent Vision, LLC Notice of privacy Practice for a more description of such uses and disclosures.

I have the right to review the notice of Privacy Practice prior to signing this consent. Excellent Vision, LLC. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Excellent Vision, Privacy officer, 155 Griffin Road Portsmouth, NH 03801.

With my consent, Excellent Vision, LLC. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice to carry out TPO, such as appointment reminders, insurance issues and any call pertaining to my clinical care.

With my consent, Excellent Vision, LLC. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By siding this form, I am consenting to Excellent Vision, LLC.'s use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Excellent Vision, LLC. may decline to provide treatment to me.

Is there a person that you authorize to receive/discuss your PHI? ____ Yes or ____ No
If yes, please indicate name and relationship: _____
Special Instructions: _____

\_\_\_\_\_  
Patient's Name (print) Date: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Name (print) Signature of Patient/Legal Guardian