BRYAN G. ARMSTRONG, O.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent for Bryan G. Armstrong, O.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). A copy of the Notice of Privacy Practices provides a more complete description of such uses and disclosures and is available to you upon request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Armstrong reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Bryan Armstrong O.D., P.O. Box 911 Bryant, AR 72089, Attn. Privacy Officer.

With this consent, Bryan G. Armstrong, O.D., or his office representative may call my home or other alternative location and leave 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, Bryant G. Armstrong, O.D. or his office representative may mail to my home or other alternative location any items that assist the practice in carrying out our TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Bryan G. Armstrong, O.D. or his office representative may e-mail to my home or other alternative location any items that assist the practice in carrying out our TPO, such as appointment cards and patient statements. I have the right to request Bryan G. Armstrong, O.D. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree with the requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Bryan G. Armstrong, O.D.'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. If I do not sign this consent, or later revoke it, Bryant G. Armstrong, O.D. may decline to provide treatment for me.

My signature also verifies t hat I have received a copy of Bryan G. Armstrong's Notice of Privacy Practices.

X____

Signature of Patient of Legal Guardian

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Minor Patient's Name Date