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Rebecca Mueller, O.D.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED**HEALTH INFORMATION (HIPAA)**

With my consent, **MATOSSIAN EYE ASSOCIATES** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review **MATOSSIAN EYE ASSOCIATES'** Notice of Privacy Practices prior to signing this consent for a more complete description of such uses and disclosures.

**Signature of Patient or Legally
Authorized Representative**
Date

Print Name of Patient
Date of Birth

**Print Name of Legally
Authorized Representative**
**Relationship to Patient
(e.g., Parent, Guardian)**

HIPAA 5-29-08

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