A BETTER VUE
EYE PHYSICIANS, LLC

4089 TAMIAMI TRAIL NORTH SUITE A103
NAPLES, FL 34103

TELEPHONE (239) 262-2020 FAX (239) 435-1084

Dear Client:

Physicians, like all providers of personal / professional services, are now required by law to inform their clients of their policies regarding privacy of client information. Physicians have been and continue to be bound by professional standards of confidentiality.

We collect non public personal information about you that is provided to us by you or obtained by us with your authorization.

For current and former clients, we do not disclose any nonpublic personal information obtained in the course of our practice except as required or permitted by law. Permitted disclosures include, for instance, providing information to our employees necessary for your care, to your individual insurance companies and medicare as required for payment for claims for you, and to other physicians for the continuance of your care. In all situations, we stress the confidential nature of information being shared.

We retain records relating to professional services that we provide so that we are better able to assist you with your medical needs and to comply information, we maintain physical, electronic and procedural safeguards that comply with our professional standards.

If you have questions, feel free to ask, because your privacy, our professional ethics, and the ability to provide you with quality care are very important to us.

Sincerely,

A Better Vue Eye Physicians, LLC and Naples Premier Surgery Center LLC

Patient Consent for Use and DISCLOSURE OF Protected Health information

With my consent, the office of Drs. David Tran and Lani Vu (herein known as "The Practice") may use and disclose my protected health information to carry out treatment, billing, and healthcare operations.

The Practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained physically in the office or by written request forwarded to the Practice office.

With my consent the Practice may leave messages:

	On my home answering machine		With my spouse
	With my children or anyone residing at my home		On my cell phone voicemail
	On my work voicemail		
	On my e-mail address. **leave address here:**		

I, _____ give permission to all my health care and medical providers and payors to disclose and release my protected health information described below to:

Name(s)	**Relationship**
_____	_____
_____	_____
_____	_____

I have the right to request that the Practice restrict how it uses or discloses my protected health information to carry out treatment, billing, and healthcare operations. However the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I have the right to refuse to sign this authorization. If I do not sign this consent, the Practice may decline to provide treatment. I also have the right to inspect or copy the information to be used or disclosed.

PRINTED NAME:_____

SIGNATURE:_____

DATE:_____ Relationship to patient if other than self:_____