Authorization for Use and Disclosure of Protected Personal Information

By signing this Authorization, you authorize [INSERT PRACTICE] ("Company") to use and disclose your protected personal information ("PI"), including your name, your email address, and information about the vision care you received (such as examinations, contact lenses, and glasses), to TeamVision, so that TeamVision can provide you with information about products and services that may interest you.

Additionally, you acknowledge and agree to the following:

- I understand that I do not need to sign this Authorization in order to receive treatment, services, or materials from Company.
- I understand that Company may receive direct or indirect remuneration from another party in connection with the use or disclosure of my PI for the purpose described above.
- I understand that I may receive a copy of this Authorization by emailing Company at [Insert Practice Email Address] or writing Company at:
  [Insert Practice's Physical Address]
- I understand that the PI subject to this Authorization may be protected by law. Certain laws may prohibit TeamVision from further disclosing my information to another party, unless another authorization is obtained from me or unless the further disclosure is specifically permitted or required by law.
- I understand that I have the right to revoke this Authorization at any time by clicking the unsubscribe button in any commercial electronic message I receive, emailing Company at [Insert Practice Email Address] or writing Company at:
  [Insert Practice's Physical Address]

  Revoking this Authorization will not have any effect on actions in reliance on the Authorization before the notice of my revocation was received.

Signature: _____

Printed Name: _____

Date: _____