CHILD EYE CARE ASSOCIATES, L.L.C.

9735 SW Shady Lane, Suite 203 Tigard, OR 97223 503.635.4436

NOTICE: PATIENT PRIVACY

We are required by Federal Law under HIPAA (Health Insurance Portability and Accountability Act) to notify you of our Patient Health Information Privacy Policy.

A copy of the policy is posted at our check-out window. You may review it there at any time or request a copy at the front desk.

We are also required to obtain your signature indicating that we have offered you a copy of our Patient Health Information Privacy Policy.

	I have received copy of the Patient Health Information Privacy Policy today. OR
	I understand I have the right to receive a copy of the policy at any time in the future at my request, but do not wish to receive one at this time.
Patier	nt Name
Repre	sentative (if patient is a minor)
Relati	onship to PatientDate
	orization to Disclose Medical Information to the Primary Care Physician and/or other physicians ipating in you/your child's medical care
	ne policy of our office to send a summary with the pertinent information to your/your child's primary ohysician after each visit or periodically for three reasons:
	To document the visit for referrals which may be required by your insurance company To keep your primary care physician updated as to the diagnosis and treatment of your/your child's eye condition
3.	In response to consultation requests by your primary care physician or another physician who referred you to this office for consultation, second opinions or treatments. We will send information to other physicians who treat you/your child at your request.
	I AGREE to the release of medical information to my/my child's primary care physician or other physicians involved in my/my child's medical care as outlined above.
	I DO NOT AGREE to the above release of medical information with the exception of:

Date

Signature