

**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 in our hallway. 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.

Patient Name \_\_\_\_\_

Representative (if patient is a minor) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

**Authorization to Disclose Medical Information to the Primary Care Physician and/or other physicians participating in you/your child's medical care.**

It is the policy of our office to send a summary with the pertinent information to your/your child's primary care physician after each visit or periodically for three reasons:

1. To document the visit for referrals which may be required by your insurance company
2. 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 releasing medical information to my/my child's primary care physician or other physicians involved in my/my child's medical care as outlined above.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

- I DO NOT AGREE to the above release of medical information with the exception of:**

\_\_\_\_\_