Acknowledgment of Notice of Privacy Practices

Coos Bay Vision Center, Inc.
986 Central Avenue PO Box 329 Coos Bay OR 97420
541.267.4224

The law requires that Coos Bay Vision Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Coos Bay Vision Center, Inc.'s Notice of Privacy Practice prior to any services offered.
___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Coos Bay Vision Center, Inc. to release my personal health information to the following individuals:

_____ _____ _____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

___ I authorize the release of medical information to my vision plan
___ I do not authorize release of medical information to my vision plan

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.
___ I authorize the use of standard email, in spite of the known risk involved, to communicate with me.
___ I do not authorize the use of standard email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____
Representative Signature Relationship to Patient