THE COLUMBIA RIVER EYE CENTER

DISEASES AND SURGERY OF THE EYE

Devin Harrison MD-Quinn Smith MD-David Wheeler MD-Brandon Walters OD

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or if the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager.

By my signature below I acknowledge receipt of the Notice of Policy Practice. This form will be retained in your medical record.

______________________________________ __________________

Signature of patient or responsible party Date

I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

Name:___________________________________ Relation:__________________

Name:___________________________________ Relation:__________________

Name:___________________________________ Relation:__________________