ACKNOWLEDGEMENT AND CONSENT

I understand that JD Harris, PC DBA Beaverton Vision World and/or Tigard Vision World, PC (referred to below as "This Practice") will use and disclose health information about me. I understand this may include information both created and received by The Practice; the information may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that The Practice may use and disclose my health information in order to:

- Plan for and make decisions about my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform administrative and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area and available on the website at www.bvweyes.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in a manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient or representative)