Bend Osteopathic Care, PC
147 SW Shevlin Hixon Dr Ste 204, Bend, OR 97702
O: 541.706.9985 ∞ F: 541.408.9853

Notice of Privacy Practices:

I understand that my health information may be created or received by Bend Osteopathic Care, PC. I understand that it may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that I have the right to receive and review a written description of how Bend Osteopathic Care, PC will handle my health information. 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 Bend Osteopathic Care, PC and my right 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 new revisions if I choose to. I also understand that a copy or summary of the most current version of Bend Osteopathic Care's ***Notice of Privacy Practices*** in effect will be posted in the waiting/reception area.

Patient Name (Please Print)_____**Date:**_____

Patient Signature (or Guardian) _____

By signing the above, I agree that I have reviewed and understand the above information and that I am entitled to have a copy of Bend Osteopathic Care's ***Notice of Privacy Practices*** if I so choose. Please inform the front desk and you will be issued a copy.

Special Permission Request:

I give permission for Bend Osteopathic Care, PC, to leave messages regarding my: ☐**Appointments and or** ☐**Simple Care Information** on any of the following **Telephone Numbers:** _____

_____ _____ **(please specify if Mobile, Home, Work, etc.)**

Patient Signature:_____**Date:** _____

I give permission to discuss/leave messages regarding my: **Treatment, Billing, and or Appointment Status** with my spouse/partner/caregiver/or N/A:_____**Tel.#(s)**_____
Name of Spouse/Partner/Caregiver/or N/A if Not Applicable (Please Print)

Patient Signature:_____**Date:** _____

This release can be revoked at any time by written permission only. I understand that I must sign/or send a written request to Bend Osteopathic Care, PC, in order to revoke this release.

Patient Signature:_____**Date:** _____