inovia
VEIN SPECIALTY CENTER

Right to Privacy

I authorize Inovia Staff to leave messages at the following phone number or e-mail address:

_____ _____

I give permission to release medical information over the phone and in person to:

_____ Relationship:_____

I understand and authorize Inovia to use my treatment results in medical research and/or advertising as long as my identity is not revealed.

I acknowledge having received a copy of the Notice of Privacy Practices for Inovia.

Signature of Responsible Party_____ Date _____

Referral Notice (SB 683) Compliance

According to (SB 683) the Oregon Health Authority Public Health Division requires a health care practitioner to notify a patient of the patient's right of choice when referred for care.

The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;

If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient; and

A health practitioner may not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

I acknowledge I have been informed of my rights and my provider/ Inovia staff is available if I have further questions or need more information.

_____ _____
Patient Name (Please Print) Signature of Responsible Party

_____ _____
Relationship to Patient (If other than self) Date