

141 Wildewood Park Drive  
Columbia, SC 29223

Telephone: 803.865.5520  
Facsimile: 803.865.5496

**Dr. John L. Mason**  
*Optometrist*

**Dr. Katie S. Mason**  
*Optometrist*



We are notifying you of an important change at Mason Family Vision. Effective February 1, 2026, we will no longer be an in-network participating provider with Community Eye Care vision plan. This was a difficult decision, reached after careful consideration of the insurance constraints that have impacted our ability to provide the level of personalized care we strive for.

We value our relationship with you and want to assure you that your ongoing care is our top priority. This change does not affect your ability to continue receiving care from us, however, your visits will be handled differently from an insurance perspective.

We will support you during this transition. You have the following options:

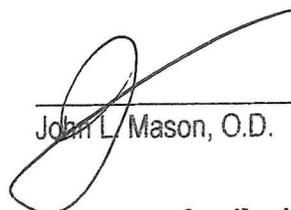
- **Continue your care with us as an out-of-network patient.** You are able to continue receiving care at our practice, but your out-of-pocket costs could be higher. We encourage you to contact Community Eye Care at 888-254-4290 directly to understand your specific out-of-network benefits and financial responsibilities.
- **Transfer your care to a new in-network provider.** If you prefer to find another provider who is in-network with your plan, go to <https://www.ccevvision.com/search> to find a provider in your area.
- **Requesting a medical record transfer.** To ensure continuity of your care, we can transfer your medical records to a new physician. To do so, please complete and sign the enclosed Authorization for Release of Medical Information form and return it to our office. The form must be signed by you, or your legal representative, to comply with privacy regulations. Once we receive the completed form, we will transfer your records to your new provider promptly and at no cost to you. Please allow 5 business days from the date we receive your request.

We understand that a transition like this can be difficult and want to make it as smooth as possible for you. Our staff is available to answer any questions you may have. Please call or text us at 803-865-5520.

We appreciate the trust you have placed in our practice. Thank you for being part of our patient family and we hope to continue serving your vision care needs.

Sincerely,

  
Katherine S. Mason, O.D.

  
John L. Mason, O.D.



John L. Mason, OD

Katherine S. Mason, OD

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION  
MEDICAL RECORD RELEASE**

Federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Most health insurers, pharmacies, doctors and other health care providers are required to comply with these federal standards.

PATIENT NAME: \_\_\_\_\_  
*Last First*

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

AT MY REQUEST, I AUTHORIZE:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

AT MY REQUEST, I AUTHORIZE:

Mason Family Vision  
141 Wildewood Park Drive  
Columbia, SC 29223  
Phone: 803-865-5520  
Fax: 803-865-5496

**TO DISCLOSE THE FOLLOWING INFORMATION:**

- any and all of the medical records pertaining to the treatment of the individual
- other \_\_\_\_\_

TO MAKE THE DISCLOSURE TO:

Mason Family Vision  
141 Wildewood Park Drive  
Columbia, SC 29223  
Phone: 803-865-5520  
Fax: 803-865-5496

TO MAKE THE DISCLOSURE TO:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

I understand the nature of this release. I understand that I am not required to sign this form. I also understand that if the person or organization I authorize to receive the information is not subject to federal health information privacy laws, that person or entity may further disclose the protected health information and federal privacy laws may no longer protect it.

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing. Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below. I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

\_\_\_\_\_  
*Signature of patient / legal guardian*

\_\_\_\_\_  
*Relationship to patient / legal authority*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
*Date*