HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign fhis acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed. dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.

Please print name of Patient

Please sign tor Patient; Guardian of Patient

Legal Representative; Guardian

Relationship of Legal Representative; Guardian

Your comments regarding Acknowledgements or Consents:

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only
Proper Sir Name
Other

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH iNFORMATION:
(This includes step parents. grandparents and any care takers who can have access to this patient's records):

Name: Relationship:
Name: Relationship:

I AUTHORIZE CONTACT FROM THIS OFF/CETO CONFIRM MY APPOINTMENTS. TREATMENT & BILLING INFORMATION VIA:

Cell Phone Confirmation
Home Phone Confirmation
Work Phone Confirmation
Text Message
Email Confirmation
Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

Cell Phone Confirmation
Text Message
Home Phone Confirmation
Email Confirmation
Work Phone Confirmation
Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

Phone Message
Text Message
Email
Any of the Above
None of the above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We. under current HIPAA Omnibus Rule, provide you Ihis information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment
I could not communicate with the patient
The patient refused to sign
The patient was unable to sign because
Other (please describe)

Signature of Privacy Officer