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

HIPAA OMNIBUS RULE

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

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 Protected Heath Information (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR X-RAYS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

1. It is our policy to address by first name when summoned in this office. If you disagree; how would you like to be address in this office?

   ☐ Proper Sir Name ☐ other _____

2. In order to help us protect your Privacy, please list the name of the physician(s) who referred you to us or any physician, person(s), step parent(s), business(s) you would like us to request or release your Personal Health Information.

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

3. Please DO NOT RELEASE any of my PHI that may be contained in my records to the following: _____

_____

4. Please DO NOT RELEASE the following PHI that may be contained in my records:_____

_____

5. I authorize contact from this office to **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** via:
   ☐ Cell Phone ☐ Email confirmation
   ☐ Home Phone ☐ Work Phone ☐ **Any of the Above**

6. I authorize **INFORMATION ABOUT MY HEALTH** be conveyed via:
   ☐ Cell Phone ☐ Email confirmation
   ☐ Home Phone ☐ Work Phone ☐ **Any of the Above**

7. I approve being contacted about **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this office via:
   ☐ Phone Message ☐ Email ☐ Any of the above ☐ **None of the above** (opt out)

_____ _____ _____
Name Signature Date

_____ _____ _____
Legal Representative Description of Authority Date

Your comments regarding Acknowledgements or Consents: _____
_____

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 this 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

☐ Patient was unable to sign because_____ ☐ Other (please describe)_____

_____ _____
Signature of privacy Officer Date