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Family Dentistry
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HIPAA OMNIBUS RULE

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

You may refuse to sign this 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 doctors/facilities in the future.**

_____ _____
Print Name Signature

_____ _____
Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

How would you like to be addressed when being called from the reception area?

____ First Name Only _____ Proper Surname ____ Other: _____

Please list any other parties that may have access to your health information: (this includes step-parents, grandparents, or any other caretakers that may have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize this office to contact me to confirm appointments, and discuss treatment and billing information via:

____ Cell Phone ____ Text Message
____ Home Phone ____ Email Address
____ Work Phone ____ All Of The Above

I authorize information about my health be conveyed via:

____ Cell Phone ____ Text Message
____ Home Phone ____ Email Address
____ Work Phone ____ All Of The Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products and 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 representative's signature on this Acknowledgement but did not because:
____ It was emergency treatment ____ The patient was unable to sign
____ I could not communicate with the patient ___ Other: _____
____ The patient refused to sign **Signature Of Privacy Officer:**
_____