HIPAA OMNIBUS RULE

Patient Acknowledgement of Receipt of Notice of Privacy Practices And Consent / Limited Authorization & Release Form

You may refuse to sign the acknowledgement & authorization. In refusing, we will 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 the healthcare providers of this office. 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 AND/OR FACILITY IN THE FUTURE.**

_____ _____

Please PRINT patient name Signature of Patient and/or Legal Guardian

_____

Signature of Witness / Office Representative

Comments (if any) regarding Acknowledgment of Consent: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes Parent(s), Step-parent(s), Grandparent(s), Sibling(s) and any other Caregiver(s) who can have access to patient's protected health information):

Spouse: _____ ___Yes ___No

Parent: _____ ___Yes ___No

Other: _____ ___Yes ___No Relationship: _____

Other: _____ ___Yes ___No Relationship: _____

I authorize contact from this office to CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFO via:
___ Cell phone ___Home phone ___Work phone ___ Email ___ Facsimile ___ **ALL INCLUDED**

I authorize INFORMATION ABOUT MY HEALTH be conveyed via:
___Cell phone ___Home phone ___ Work phone ___Email ___ Facsimile ___**ALL INCLUDED**

In signing this HIPAA Patient Acknowledgment Form, you have acknowledged and authorized, that this office may recommend products or services to promote your improved health. We understand current HIPAA Omnibus Rule and provide you this information with your knowledge and consent.

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Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign ___ Communication barrier ___ Emergency situation occurred with patient ___ Other (explain): _____

_____ (Signature of Privacy Official)