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 DOTOR/FACILITIES IN THE FUTURE.

_____ _____
Please print your name Please sign your name

_____ _____
Legal Representative Description of Authority

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 OFFICE TO **CONFIRM MY APPOINTMENT, TREATMENT, AND BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ Any of the Above

I AUTHORIZE **INFORMATION ABOUT** MY HEALTH BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ 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 HIIPAA 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 representative's) 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 Date