HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICESAND 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.

Today's 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 ANOTHER PROVIDER/FACILITIES IN THE FUTURE.

____ ____

Print name of the Patient | Signature/ Signature of Guardian, if Patient is a minor

____ ____

Legal Representative/Guardian, if Patient is a minor | Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents:

____

HOW DOES THE PATIENT WANT TO BE ADDRESSED WHEN SUMMONDED FROM THE RECEPTION AREA:
(First Name, Proper Surname only, other) ____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION (ie. billing, treatment, confirmation of appointments, oral hygiene status, treatment progress).
This includes parents of non-minors, stepparents, grandparents and any care takers who can have access to this patient's records:

Name: __________________________________ Relationship: ___________________________________
Name: __________________________________ Relationship: ___________________________________

I AUTHORIZE CONTACT FROM THIS OFFICE REGARDING BILLING INFORMATION, TREATMENT &/OR TO CONFIRM MY APPOINTMENTS VIA:

Cell phone #: Y/N ___________
Home #: Y/N ___________
Work Phone #:Y/N ___________
Email: Y/N ___________

**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 an emergency treatment
____I could not communicate with the patient
____The patient refused to sign
____The patient was unable to sign because of (please describe):_______________________
____Other (please describe):____