

**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 will not be allowed to process your insurance claims.**

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Surname 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: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation (Call or Message) | <input type="checkbox"/> Email Message |
| <input type="checkbox"/> Home Phone Confirmation (Call or Message) | <input type="checkbox"/> US Postal Mailing |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation (Call or Message) | <input type="checkbox"/> Email Message |
| <input type="checkbox"/> Home Phone Confirmation (Call or Message) | <input type="checkbox"/> US Postal Mailing |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the above |

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 DOCTOR / FACILITIES IN THE FUTURE.

Please ***print*** name of Patient

Please ***sign*** Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Representative / Guardian

Office Use Only Below

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 | _____ |
| The patient was unable to sign because | _____ |
| Other (please describe) | _____ |

Signature of Privacy Officer