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HIPAA OMNIBUS RULE

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

Date:___________________ Patient Name: ____

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

❑ First Name ❑ Proper Surname ❑ Other ______________________

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes parents, other family members, and any care takers who can have access to this patient's records.)

NOTE: we can ONLY discuss information about the patient with relations listed here:

Name:____ Relationship: ______________________________

Name:____ Relationship: ______________________________

Name:____ Relationship:______________________________

Name: ____ Relationship: ______________________________

In signing this HIPAA 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 or consent.

In signing this HIPAA Patient Acknowledgement Form, you agree to allow us or our agents to contact you via telephone, text message or e-mail, directly or by using a dialer, automatic telephone dialing system, interactive voice recognition system, or artificial or pre-recorded voice or message. This contact may be used for things such as appointment confirmations, treatment and billing information, information about your health, etc.

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. **YOUR SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD YOU REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/ FACILITIES IN THE FUTURE.**

___________________________________ ___________________________________

Please ***print*** name of Patient Please ***sign*** Patient/Guardian of Patient

___________________________________ ___________________________________

Please ***print*** name of Guardian (if applicable) Relationship of Guardian/Responsible Party

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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 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 ___________________________________