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 DOCTOR / FACILITIES IN THE FUTURE.

Please print the patients 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 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: __________________________

__________________________________________________________________________________________

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

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ Any of the Above

I AUTHORIZE DETAILED INFORMATION ABOUT MY HEALTH BE CONVEYED VIA: (INCLUDING VOICEMAIL)

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ 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 ☐ Any of the Above

☐ Text Message ☐ None of the above (opt out)

☐ Email

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 and consent.