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: _____

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 SUMOMNED FROM THE RECEPTION AREA (First Name Only, Proper Sir Name, Other): _____

PLEASE LIST ANY OTHER PARITES 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 **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

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:

Cell Phone Confirmation: ☐

Text Message to my Cell Phone: ☐

Home Phone Confirmation: ☐

Email Confirmation: ☐

Work Phone Confirmation: ☐

Any of the Above: ☐

None of the Above (opt out): ☐

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.

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: