



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 a copy of the currently effective Notice of Privacy Practices for this healthcare facility is available upon request. 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 for Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

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: \_\_\_\_\_

AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- Cell Phone Confirmation
Home Phone Confirmation
Work Phone Confirmation
Any of the Above

ARE WE ABLE TO LEAVE A DETAILED MESSAGE IF WE GET A VOICEMAIL?

- Yes No

AUTHORIZE THIS OFFICE TO POST PICTURES OF MY CHILD OR MYSELF IN AND/OR OUTSIDE OF THE OFFICE, INCLUDING SOCIAL MEDIA SITES IF PERMISSION IS VERBALLY OBTAINED FIRST.

- Yes No

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 \_\_\_\_\_