HIPAA OMNIBUS RULE

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

You may refuse to sign this acknowledgement and authorization.
In refusing we will not be able to process your insurance claims so you will be responsible for payment in full of any and all visits.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice Of Privacy Practices for this healthcare facility.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE IF I REQUEST TESTING OR TREA™ENT RESULTS BE SENT TO ANOTHER DOCTOR/FACILITY IN THE FUTURE.

_____ _____

Please **PRINT** your name Please **SIGN** your name

_____ _____

Legal Representative Description of Authority

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:
_____ FIRST NAME _____ PROPER SURNAME _____OTHER _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouses 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 APPOIN™ENTS OR TREA™ENT AND BILLING INFORMATION VIA:**

_____ CELL PHONE _____ HOME PHONE CONFIRMATION ____ WORK PHONE CONFIRMATION
#_____ _____ _____

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

_____ CELL PHONE _____ HOME PHONE CONFIRMATION ____ WORK PHONE CONFIRMATION

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

_____ CELL PHONE _____ HOME PHONE CONFIRMATION ____ WORK PHONE CONFIRMATION

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, 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 reason

_____Print and Signature of Privacy Officer