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** your name* *Please **sign** your name*

_____ _____

Legal representative *Description of authority*

Your comments regarding Acknowledgement or Consents: _____

_____

How do you want to be addressed when summoned from the reception area?

❑ First Name Only ❑ Surname ❑ Other _____

Please list any other parties who can have access to your health information:
(This includes step parents, grandparents and any caretakers 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 (address: _____)

❑ Work Phone Confirmation ❑ ANY OF THE ABOVE

I authorize information about my health to be conveyed via:

❑ Cell Phone Confirmation ❑ Text Message To My Cell Phone ❑ Home Phone Confirmation

❑ Email Confirmation (address: _____)

❑ Work Phone Confirmation ❑ ANY OF THE ABOVE

I approve being contacted about special services, events or new health info on behalf of this Healthcare Facility via:

❑ Phone Message ❑ Text Message ❑ Email

❑ 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 representative's) signature on this Acknowledgment 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 ❑ Other (please describe)

Signature of Privacy Officer _____

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