Patient acknowledgement of receipt of notice 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 (MM/DD/YY): ___/___/___
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.**

_____ _____
Name of patient (please print) Signature (patient/guardian of patient)

_____ _____
Legal representative/guardian Relationship of legal representative/guardian

Your comments regarding acknowledgements or consents: _____

_____

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

First name only Last name only 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 <u>confirm my appointments, treatment, & billing information</u> via:

First name only
Text message to my cell phone
Home phone confirmation
Email confirmation
Work phone confirmation
Any of the above

I authorize <u>information about my health</u> be conveyed via:

First name only
Text message to my cell phone
Home phone confirmation
Email confirmation
Work phone confirmation
Any of the above

I approve being contacted about <u>special services, events, fundraising efforts or new health info</u> 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 representatives) 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 because Other (describe) _____