PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
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: ______________________ Patient Name: ____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA?

___ First Name Only ___ Proper Surname ___Other ___________________________

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION (This includes spouse, parents, step parents, grandparents or other 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 ___ Email Confirmation

___ Text Message to my Cell Phone ___ Work Phone Confirmation

___ Home Phone Confirmation ___ Any of the Above

I AUTHORIZE MY HEALTH INFORMATION BE CONVEYED VIA:

___ Cell Phone Confirmation ___ Email Confirmation

___ Text Message to my Cell Phone ___ Work Phone Confirmation

___ Home Phone Confirmation ___ Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUNDRAISING EFFORTS or NEW HEALTH INFO on behalf of this office via:

___ Phone Message ___ Any of the Above

___ Text Message ___ None of the Above

___ Email

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 you knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practice for this office. 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 Patient/ Guardian of Patient

____ ____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

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 patient
___The patient refused to sign
___ The patient was unable to sign because ____
___ Other (please describe) ____

Signature of Privacy Officer ____