

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 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** patient name

Please **sign** your name

Legal Representative for patient signature

Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO YOU CONSENT TO HAVING ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM APPOINTMENTS VIA:

_____ Receives email correspondences Email Address: _____

_____ Receives text messages Cell Phone #: _____

_____ Home Phone Phone #: _____

In signing this HIPAA 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 acknowledgement 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 _____

Signature of Privacy Officer