HIPPA 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/facility in the future.**

_____ _____

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

_____ _____

Legal Representative Description of Authority

Your comments regarding acknowledgements or consents: _____

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

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMAITON:
(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
☐ Home Phone Confirmation
☐ Work Phone confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of above**

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

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on BEHALF OF THIS HEALCARE FACILITY VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of above**

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 (please describe)

ILY DENTAL LLC

_____

Signature of Privacy Officer