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 <u>may not be allowed</u> to process your* insurance claims.**

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

☐ First Name Only ☐ Proper Surname ☐ 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:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE <u>INFORMATION ABOUT MY HEALTH</u> BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT <u>SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO</u> on behalf of Lowes Island Dentistry via:

□ Phone Message
□ Text Message
□ Email
☐ None of the above (opt out)

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.

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.

_____ _____ **Date:** _____
Printed name of Patient **Signature of Patient / Guardian of Patient**

_____ _____ **Date:** _____
Guardian / Legal Representative **Signature of Patient / Guardian of Patient**

<u>Office Use Only</u>
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) ___ _____

Signature of Privacy Officer (Office Personnel)

HIPAA made EASY™
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