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's family name Guardian/Legal Representative signature

_____

Relationship of Guardian/Legal Representative

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR CHILD'S 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 **CONFIRM MY CHILD'S APPOINTMENTS, TREATMENT & BILLING INFORMATION AND OFFICE NOTIFICATIONS (UNEXPECTED OFFICE CLOSURES, SPECIAL OFFICE PROMOTIONS)** VIA:

☐ Cell Phone Confirmation/Text Message_____

☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Email Confirmation_____
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY CHILD'S HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation/Text Message_____

☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Email Confirmation_____
☐ **Any of the Above**

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 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