



HIPPA OMNIBUS RULE
PATIENT ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED
AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In reusing we may not be allowed to process your insurance claims.

Date: _____

This 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 effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

Please PRINT name of PATIENT

Please SIGN for Patient/Guardian of Patient

Legal Representative/Guardian

Relationship of Legal Representative/Guardian

Please list any other parties who can have access to your child's health information: (this includes step-parents, grandparents and caretakers who can have access to patient's records)

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

In signing this HIPPA 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 HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Employee, I attempted to obtain the patients (or representatives) signature on this Acknowledgement but did not because:

- | | |
|--|--------------------------|
| It was emergency treatment | <input type="checkbox"/> |
| I could not communicate with the patient | <input type="checkbox"/> |
| The patient refused to sign | <input type="checkbox"/> |
| The patient was unable to sign because | <input type="checkbox"/> |
| Other (please describe) | <input type="checkbox"/> |

Signature of Employee