

Signature of Office Staff of Doctors

## **HIPAA Omnibus Rule**

## Patient acknowledgement of receipt of notice of privacy practices and consent / limited authorization & release form

this signed, dated document shall be as effective as the original.  My signature will also serve as a personal health information document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.  Please print name of patient  Please print name of patient  Please print name of patient  Please grint name of patient  Please grint name of patient  Please grint name of patient  Relationship to patient  Your comments regarding Acknowledgements or Consents:  Contact Information:  Address:  Home phone #:  Cell phone #:  How do you want to be addressed when welcomed from the reception area:    First Name Only	You may refuse to sign	this acknowledgement & authorizatio	n. In refusing we may not be allowed to process your insurance claims.	
Please print name of patient	Date:  The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for our dental office. A copy of this signed, dated document shall be as effective as the original.			
Legal Representative / Guardian  Relationship to patient  Your comments regarding Acknowledgements or Consents:  Contact Information:  Address:  Home phone #:  Cell phone #:  Cell phone #:  How do you want to be addressed when welcomed 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, nannies, and any care takes 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, and health information be conveyed via: (Please check one only)  Cell Phone   Email (please list email below)  Patient or Guardian Signature:  Date  Office Use Only  As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:  It was emergency treatment   I could not communicate with the patient  I could not communicate with the patient  The patient refused to sign			mation document release should I request treatment or radiographs be sent	
Your comments regarding Acknowledgements or Consents:    Contact Information:	Please <u>print</u> name of patient		Please <u>sign</u> patient or guardian	
Contact Information:  Address:  Home phone #:  Cell phone #:  Home phone #:  Home phone #:  Home phone #:  Home phone #:  Cell phone #:  Home phone #:  Please list any other parties who can have access to your health information:  (This includes step parents, grandparents, nannies, and any care takes 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, and health information be conveyed via: (Please check one only)  Cell Phone  Home Phone  Email (please list email below)  Text Message  Office Use Only  As Privacy Officer, l attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:  It was emergency treatment  I could not communicate with the patient  The patient refused to sign	Legal Representative / Guardian		Relationship to patient	
Address:    Home phone #:   Cell phone #:	Your comments regard	ing Acknowledgements or Consents:		
Home phone #:    Cell phone #:   How do you want to be addressed when welcomed from the reception area:   First Name Only	Contact Information	:		
How do you want to be addressed when welcomed from the reception area:    First Name Only	Address:			
Prist Name Only   Proper Surname   Other:	Home phone	#:	Cell phone #:	
This includes step parents, grandparents, nannies, and any care takes who can have access to this patient's records)  Name:	<u> </u>		·	
Name: Relationship:    Relationship:   Relationship:     I authorize contact from this office to confirm my appointments, treatment, billing, and health information     Cell Phone	•	•		
Name: Relationship:  I authorize contact from this office to confirm my appointments, treatment, billing, and health information be conveyed via: (Please check one only)    Cell Phone		s, grandparents, nannies, and any care tak		
I authorize contact from this office to confirm my appointments, treatment, billing, and health information be conveyed via: (Please check one only)    Cell Phone	Name:		<u> </u>	
check one only)  Cell Phone	Name:		Relationship:	
Text Message	I authorize contact fr check one only)	om this office to confirm my appo	intments, treatment, billing, and health information be conveyed via: (Please	
Patient or Guardian Signature:  Office Use Only  As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:  It was emergency treatment I could not communicate with the patient The patient refused to sign	Cell Phone	Home Phone	Email (please list email below)	
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It was emergency treatment  I could not communicate with the patient  The patient refused to sign	Office Use Only		_	
I could not communicate with the patient  The patient refused to sign	As Privacy Officer, I attempte	d to obtain the patient's (or representative's) sig	gnature on this Acknowledgement but did not because:	
The patient refused to sign				
		•		
The patient was unable to sign because	•	-		
	•			
Other (please describe)	Other (plea	se describe)	<u> </u>	

Date