HIPAA NOTICE OF PRIVACY POLICY

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES 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:_________________________ **PATIENT:**____

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

☐ First Name Only ☐ Proper Surname ☐ Other ____________________

Please list any other parties who are actively involved in your health care and 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 THE OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

- ☐ Cell phone Confirmation
- ☐ Home phone confirmation
- ☐ Work phone confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ Any of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTH TO BE CONVEYED VIA:

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

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

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ Any of the Above
- ☐ None of the Above
- ☐ (opt out)

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.

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 NAME of Patient — Patient/Parent/Guardian Signature

______________________________________ ______________________________________

Please PRINT NAME of Representative — Relationship to Patient

OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other:____

Signature: Today's Date: