DECATUR
FAMILY DENTISTRY

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# 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 (Protected Health Information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

***Print name of Patient*** _____

***Please sign for Patient / Guardian of Patient*** _____

***Legal Representative / Guardian*** _____

***Relationship of Legal Representative / Guardian*** _____

Your comments regarding Acknowledgements of Consents:

_____

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 stepparents, grandparents and any caretakers 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 INFORMATION VIA:
Cell Phone Confirmation _____ Home Phone Confirmation _____
Work Phone Confirmation _____ Text Message to my Cell _____
Email confirmation _____ Any of the above _____

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

Cell Phone Confirmation _____ Home Phone Confirmation _____
Work Phone Confirmation _____ Text Message to my Cell _____
Email 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.*

**Office Use Only**
As Privacy Officer I attempted to obtain the patent'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 (describe) _____

Signature of Privacy Officer _____

***HIPAA made EASY™***
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