HIPAA Omnibus Rule - Patient Acknowledgement Form for Receipt of Notice of Privacy Practices

How would you like to be addressed from the 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 THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:		
__ Cell phone confirmation	__ Home phone confirmation	__ Email confirmation
__ Text message to my cell phone	__ Work phone confirmation	__ Any of the above
I AUTHORIZE INFORMATION **ABOUT MY HEALTH** BE CONVEYED VIA:		
__ Cell phone confirmation	__ Home phone confirmation	__ Email confirmation
__ Text message to my cell phone	__ 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	__ Email	__ None of the above (opt out)
__ Text message	__ 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 HPIAA Omnibus rule, provided 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.

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

Patient Name: _____ Signature: _____

Date: _____

Legal Representative/Guardian Name: _____ Signature: _____

Date: _____

OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgment of our HIPAA Omnibus Rule due to the following reason:

_____ The Patient refused to sign _____ It was emergency treatment/situation

_____ I could not communicate with the patient _____ Other _____