Notice of Privacy Practices

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization, but in refusing we may not be allowed to process your insurance claims. 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 RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____	_____	_____	_____
Please **PRINT** your name	Date of Birth	Please **SIGN** your name	Date
_____	_____	_____	
Legal Representative	Date of Birth	Description of Authority	

Your comments regarding Acknowledgements or 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 step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

□ Home Phone _____	□ OK to Leave Detailed Message	□ Leave Message for Call-back
□ Cell Phone _____	□ OK to Leave Detailed Message	□ Leave Message for Call-back
	□ OK to Text a Detailed Message	

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

□ Cell Phone Confirmation	□ Home Phone Confirmation
□ Work Phone Confirmation	□ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **NEW HEALTH INFO** ON BEHALF OF THIS OFFICE VIA:

□ Phone Messages	□ Email	□ US Mail
□ **None of the above** (opt out)	□ **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 HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient/representative signature on this Acknowledgement but did not because:

It was emergency treatment	____	Patient was unable to sign because: _____
Could not communicate with patient	____	Other (please describe): _____
The patient refused to sign	____	Privacy Officer: _____ Date: _____