

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient Address:

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the notice of Privacy Practices because:

___ **An emergency existed and a signature was not possible at the time.**

___ **The individual refused to sign.**

___ **A copy was mailed with a request for a signature by return mail.**

___ **Unable to communicate with the patient for the following reason:** _____

___ **Other:** _____

Prepared by: _____

Signature: _____

Date: _____

**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.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this Health care 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 your name

Please sign your name

Legal Representative

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 Sir Name 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 CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

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

I AUTHORIZE INFORMATION ABOUT MY HEALTH 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.

----- Office Use Only-----

As Privacy Officer, I attempted to obtain the patient'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 (please describe) _____