OmniSmiles

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 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 BY, OR RADIOGRAPHS RELEASED TO OTHER ATTENDING DOCTOR(S)/FACILITY(S) IN THE FUTURE.

_____	_____	_____
Patient Name: Please Print	Patient signature	Date
_____	_____	_____
Legal Representative Name: Print	Legal Representative Signature	Date

Description of Authority of Legal Reprensentative (i.e. Parent/Legal Guardian): _____

Please list specific restrictions to release of PHI, if desired: _____

Please list any other parties who can have access to your health information (PHI): (this includes step-parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

How do you wish to be addressed when called from reception area: ☐ First Name Only/ ☐ Proper Name (Mr. Mrs. Ms. Dr. Etc)

I authorize contact from this office to confirm my appointments, treatment and billing information via:

☐ Cell phone confirmation	☐ Work phone	☐ Text message to cell phone
☐ Home phone	☐ E-mail	☐ Any of the above

I authorize information about my health be conveyed via:

☐ Cell phone confirmation	☐ Work phone	☐ Text message to cell phone
☐ Home phone	☐ E-mail	☐ Any of the above

I approve being contacted about special services, events, fund raising efforts or new health information on behalf of this healthcare facility via:

☐ Cell phone confirmation	☐ Work phone	☐ Text message to cell phone
☐ Home phone	☐ E-mail	☐ 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 with this information with your knowledge and consent.

Office use only

As privacy officer, I attempted to obtain this patient's (or representative's) signature on this acknowledgement but did not because:

☐ The patient refused to sign

☐ It was an emergency treatment

☐ I could not communicate with the patient

☐ The patient was unable to sign because: _____

☐ Other: _____

Privacy officer: _____	_____	_____
Signature	Printed Name	Date