

**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: \_\_\_\_\_

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 SUMOMNED FROM THE RECEPTION AREA (First Name Only, Proper Sir Name, Other): \_\_\_\_\_

PLEASE LIST ANY OTHER PARITES 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:

Cell Phone Confirmation:

Text Message to my Cell Phone:

Home Phone Confirmation:

Email Confirmation:

Work Phone Confirmation:

**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)

Signature of Privacy Officer: