HIPAA Rule Acknowledgement

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.

- How do you want to be addressed when summoned from the reception area?

  ☐ First Name ☐ Other_____

- Please list any other parties who can have access to your health information:

  Name:_____Relationship:_____

- I authorize this office to contact me

  ☐ confirm my appointments, treatment & billing information

  ☐ Information about my health

  ☐ Special services, events, fund raising efforts or new health information on behalf of this healthcare facility

  Using

  ☐ Cell Phone ☐ Home Phone ☐ Email

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.

Print Name_____

Signature_____ Date _____

Office Use Only

As privacy Officer, I attempted to obtain the patient's or representative's 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

_____
Signature of Privacy Officer