HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES 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: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

□ First Name Only □ Proper Surname □ Other _____

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

□ **Any of the Below** □ Cell Phone Confirmation

□ Text Message to my Cell Phone □ Work Phone Confirmation

□ Home Phone Confirmation □ Email Confirmation

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

□ **Any of the Below** □ Cell Phone Confirmation

□ Text Message to my Cell Phone □ Work Phone Confirmation

□ Home Phone Confirmation □ Email Confirmation

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 TREATEMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please print name of Patient **Please sign Patient / Guardian of Patient**

_____ _____

Legal Representative / Guardian **Relationship of Legal Representative / Guardian**

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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) _____

Designation for Release of Medical Information to a Family Member, Friend, or Legal Representative

It is the doctor's responsibility to ensure that the doctor-patient relationship is confidential. The Health Insurance Portability and Accountability Act (HIPAA) allows doctors to use their professional judgment on disclosing certain personal health information to family, friends etc without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Dental Solutions realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical/dental condition or needs. Your dentist wants you to be able, if you so desire, to identify individuals whom you want Dental Solutions' teams members to speak with about your medical/dental conditions. To enable that, we would ask that your complete this form.

- This designation is valid until you cancel in writing.
- If you designate no one, Dental Solutions will not release information to any family member, friend or legal representative.

Designation Statement

I, _____, designate the following individuals to be able to speak with a team member at Dental Solutions on my behalf. I hereby give permission to Dental Solutions through its doctors and team members to release any information about my medical/dental condition, insurance information, or status of my account. I release Dental Solutions, its doctors and team members from any claim of confidentiality in connections with the release of this information.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____

Patient / Guardian / Legal Representative (Signature) Date

_____

Name of dependents under 18 years of age

I DECLINE to designate another person to speak with Dental Solutions' doctors or team members.

_____

Patient / Guardian / Legal Representative (Signature) Date

_____

Name of dependents under 18 years of age