

Four Lakes Dental
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:

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.**

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

Relationship of Legal Representative / Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes spouses, 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**

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