REIDER FAMILY DENTISTRY

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 our dental office. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a personal health information document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.

Please ***print*** name of patient _____ Please ***sign*** patient or guardian _____

Legal Representative / Guardian _____ Relationship to patient _____

Your comments regarding Acknowledgements or Consents:

_____

_____

Contact Information:

Address: _____

Home phone #: _____ Cell phone #: _____

How do you want to be addressed when welcomed from the reception area:

☐ First Name Only ☐ Proper Surname ☐ Other: _____

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

(This includes step parents, grandparents, nannies, and any care takes 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, and health information** be conveyed via: (Please check one only)

☐ Cell Phone ☐ Home Phone ☐ Email (please list email below)

☐ Text Message ☐ Work Phone _____

_____ _____

Patient *or Guardian* ***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 ☐
- Other (please describe) ☐

_____

_____

_____ _____

Signature of Office Staff of Doctors *Date*