SG DENTISTRY, P.C.

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.

Date:____________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Policies for this healthcare facility. A copy of this signed, dated document shall be 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.**

______________________________ Please **print** name of Patient

______________________________ Please **sign** Patient/Guardian of Patient

______________________________ Legal Representative/Guardian

______________________________ Relationship of Legal Representative/Guardian

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PLEASE LIST ANY OTHER PARTIES 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:**

- ____ Cell Phone Confirmation
- ____ Home Phone Confirmation
- ____ Work Phone Confirmation
- ____ Text Message to my Cell Phone
- ____ Email Confirmation
- ____ **Any of the Above**

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

- ____ Cell Phone Confirmation
- ____ Home Phone Confirmation
- ____ Work Phone Confirmation
- ____ Text Message to my Cell Phone
- ____ Email 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 this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative) 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 ____
- Other (please describe) ____

______________________________ Signature of Privacy Officer