

**HIPPAA 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.**

\_\_\_\_\_  
Please **print** name of Patient

\_\_\_\_\_  
Please **sign** for Patient/Guardian of Patient

\_\_\_\_\_  
Legal Representative/Guardian

\_\_\_\_\_  
Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_  
\_\_\_\_\_

YOU WILL BE SUMMONED FROM THE RECEPTION AREA BY YOUR FIRST NAME.

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 patients records):

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA ALL PHONE NUMBERS GIVEN OVER THE PHONE AND PROVIDED ON MY PATIENT INFORMATION SHEET.

In signing this HIPPAA 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 HIPPAA Omnibus Rule, provide you this information with your knowledge and consent.

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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)

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Signature of Privacy Office or Authorized Staff Member

Date