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

________________________________	_______________________________________
(PRINT NAME)	(SIGNATURE)
________________________________	_______________________________________
(IF UNDER 18: GUARDIAN SIGNATURE)	(GUARDIAN'S RELATIONSHIP TO PT)

PLEASE LIST ANY OTHER PERSON(S) WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes the insurance provider, step parents, grandparents and any care takers)

_______________________________________	____
(NAME)	(RELATIONSHIP)
_______________________________________	____
(NAME)	(RELATIONSHIP)
_______________________________________	____
(NAME)	(RELATIONSHIP)

I AUTHORIZE CONTACT PERTAINING TO MY APPOINTMENTS AND HEALTH CARE INFORMATION VIA:

_____________________________________	____
(EMAIL ADDRESS)	(CELL PHONE)
______________________________________	____
(HOME PHONE)	(OTHER)

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient'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 ____

____
(Signature of Privacy Officer)