HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT **OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE**

You may refuse to sign this acknowledgement but, in refusing we *will 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 **BALMORAL DENTAL CENTER.** A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITY IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes and any care takers, step parents, grandparents who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this via:

□ Phone Message
□ Text Message
□ Email
☐ Any of the Above
☐ None of the above (opt out)

I AUTHORIZE PERMISSION TO HAVE MY DENTAL WORK AND/OR PHOTOGRAPHS POSTED WITHIN THE DENTAL PRACTICE AND/OR ON THE WEBSITE, SOCIAL MEDIA, PRINT ADS AND ALL OTHER MARKETING OR ADVERTISING EFFORTS THAT PROMOTE BALMORAL DENTAL CENTER.

□ Yes
□ No

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
___ The patient refused to sign
___ Other (please describe)
___ I could not communicate with the patient
___ The patient was unable to sign because

_____

Signature of Privacy Officer