

# R. Keith Thetford, DDS

## 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 TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITY'S IN THE FUTURE.

\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Please sign your name

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Description of Authority

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

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:  
(This includes step parents, grandparents and any caretakers 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 VIA:

- Cell Phone Confirmation  
 Home Phone Confirmation  
 Work Phone Confirmation       Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- Cell Phone Confirmation  
 Home Phone Confirmation  
 Work Phone 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 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  
 I could not communicate with the patient  
 The patient refused to sign  
 The patient was unable to sign because  
 Other (please describe)

\_\_\_\_\_  
Signature of Privacy Officer