MAD RIVER
FAMILY DENTAL

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____ Patient Name:_____

How do you want to be addressed when summoned from reception area:

☐ FIRST NAME ONLY ☐ PROPER SURNAME ☐ OTHER _____

Please list any other parties who are actively involved in your health care and 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 via:

☐ CELL PHONE CONFIRMATION ☐ EMAIL CONFIRMATION ☐ TEXT MESSAGE TO MY CELL PHONE
☐ WORK PHONE CONFIRMATION ☐ HOME PHONE CONFIRMATION ☐ ANY OF THE ABOVE

I authorize information about my health can be conveyed via:

☐ CELL PHONE CONFIRMATION ☐ EMAIL CONFIRMATION ☐ TEXT MESSAGE TO MY CELL PHONE
☐ WORK PHONE CONFIRMATION ☐ HOME PHONE CONFIRMATION ☐ ANY OF THE ABOVE

I approve being contacted about special services, events, fund raising efforts or new health info on behalf of this Healthcare Facility via:

☐ PHONE MESSAGE ☐ TEXT MESSAGE ☐ EMAIL
☐ ANY OF THE ABOVE ☐ NONE OF THE ABOVE (OPT OUT)

In signing this HIPAA Patient Acknowledgment 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.

The undersigned acknowledges receipt of a copy of the current 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 Patient/Guardian of Patient

_____ _____
Legal Representative/Guardian Relationship of Legal Representative/Guardian