HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, 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: _____

Please *PRINT* Patient Name: _____

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PLEASE LIST ANYONE WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION FROM OUR OFFICE:

(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Please *SIGN* Patient/Guardian of Patient **Relationship to Patient if Applicable**

By signing, I acknowledges receipt of a copy *or* access to a copy of the currently effective Notice of Privacy Practices for Southpointe Dental. A copy of this signed and 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.***

You may revoke such permission at any time by writing to our Practice Privacy Officer.

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) _____

_____

Southpointe Dental Employee Initials & Date