Southpointe Dental
James Lichtsinn, DDS

DATE: _____

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.

****

I AUTHORIZE INFORMATION ABOUT MY HEALTH, MY ACCOUNT & MY APPOINTMENTS BE CONVEYED FROM THIS OFFICE VIA:

☐ **Phone Call to CELL** (_____) _____ ☐ **& OR/ Text** (_____) _____Verizon / Sprint / AT&T / T-Mobile

☐ **Email** _____ ☐ **Fax** (_____) _____

☐ **Phone Call Landline** (_____) _____

PLEASE LIST ANY OTHER PARTIES 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: _____

_____ _____

Please *PRINT* patient name **Please *SIGN* Patient/Guardian of Patient**

_____

Relationship of Guardian / Legal Representative

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