Eric Batterton DDS

HIPPA 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 able to process you insurance information.)

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/FACILITYS IN THE FUTURE.

_____ _____

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

Legal Representative Description of authority

Your comments regarding Acknowledgements of Consents:_____

PLEASE LIST ANY OTHER PARTIES 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**

___Cell phone confirmation ___Text Message to my cell phone
___Home phone confirmation ___ Email Confirmation
___Work phone confirmation ___**Any of the Above**

I authorize **INFORMATION ABOUT MY HEALTH** be conveyed VIA:

___Cell phone confirmation ___Text Message to my cell phone
___Home phone confirmation ___Email Confirmation
___Work phone confirmation ___**Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, OR NEW HEALTH INFO** on behalf of this Healthcare Facility via:

____Phone message ___Any of the Above
___Text message ___None of the Above ___Email

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_____