HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES AND CONSENT LIMITED AUTHORIZATION AND RELEASE FORM.

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process our 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.

_____
Sign your name

_____
Print your name

_____
Legal Representative Description of Authority

_____ _____
Phone Number Email

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?
__First Name only __Proper Sir Name ____No Preference

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 AND BILLING INFORMATION** VIA:

__ 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, FUND RAISING EFFORTS, OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

____ Phone Message ___Cell Phone Via Voice or Text
_____ Email ____ Social Media (Facebook etc.)
_____ **ALL OF THE ABOVE ___ NONE OF THE ABOVE**

Photo consent form

I hereby give Carla K. Brink, D.D.S. and any and all employees and or agents of Carla K. Brink, D.D.S., the right and permission to use and/or publish photographs of me for art, promotional and educational purposes (including but not limited to, advertising, commercial or display of use)

Release of Claims:

I hereby release and discharge Carla K. Brink, D.D.S. and all persons functioning under her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the images, alteration, distortion or use of composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

Initial The Following:

_____ Yes, you may use my photos

_____ No, you may not use my photos

_____ _____
Signature Date

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 HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

FOR OFFICE USE ONLY

As Privacy Officer, I attempted to obtain patient's or (representative's) signature on this Acknowledgment 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 _____
Other_____

Cynthia L. Ollom