GLENNS BAY DENTAL ASSOCIATES
HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSET/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign however in refusing may not be allowed to process 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.
MY SIGNATURE WILL ALSO RESERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_______________________________ _______________________________
Please PRINT your name Please SIGN your name

________________________________ ________________________________
Legal Representative Description of Authority

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?
_____ First Name Only _______ Proper Sur Name _____ Other ____________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL/HEALTH INFORMATION:
(This includes family members and any caretakers who can have access to this patient's records):
NAME: _________________________ RELATIONSHIP:___________________ PHONE: _________________
NAME: _________________________ RELATIONSHIP:___________________ PHONE: _________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENTS & BILLING INFORMATION VIA:
_____Cell Phone or Voicemail Confirmation _____US Postal Service/Mail
_____Home/Work Phone Confirmation or Answering Machine _____Any of the above
Designated persons at home or contact phone numbers NAME ____________________________
RELATIONSHIP TO PATIENT__________________________________

I AUTHORIZE INFORMATION ABOUT MY DENTAL/HEALTH BE CONVEYED VIA:
_____Cell Phone or Voicemail Confirmation _____US Postal Service/Mail
_____Home/Work Phone Confirmation or Answering Machine _____Any of the above
Designated persons at home or contact phone numbers NAME ____________________________

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved dental/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 _____Patient was unable to sign because
_____ I could not communicate with the patient _____Other
_____The patient refused to sign

____
Signature of Privacy Officer