HIPAA 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 ALLOWED TO PROCESS YOUR INSURANCE CLAIMS.

Please print name of patient: _____ **Date of Birth**: _____
Legal Representative / Guardian: _____ Relationship to patient: _____

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.

I authorize contact from this office to Confirm my Appointment, Treatment, & Billing Information VIA:

____ My personal voice mail ____ Text Message to my cell phone
____ Spouse/Parent ____ Work Phone Confirmation
____ Email confirmation ____ Any of the Above

Please list any other parties who can have access to your health information:
(This includes spouse, friend, care taker or family member ie; parent, step parent, child, or grandparent)

Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____ (Initial here) Acknowledge that **Roy D. Jennings, DDS** corresponds electronically and /or over the phone with referral doctors with health information.
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.

You may revoke this authorization in writing or by updating this form.

_____ _____
Patient Signature Date

OFFICE USE ONLY:

_____
Signature of Privacy Officer