

DENTISTRY OF WISCONSIN
HIPAA OMNIBUS RULE

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

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledgement 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 ANOTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

Please print name of Patient

Please sign for Patient/Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative/Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes spouses, 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

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 remunerations from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you with information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's or representative's 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 _____

Other (describe) _____

Signature of Privacy Officer