PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF 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 your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice or Privacy Practices for this dental 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 BY *UNENCRYPTED EMAIL* TO OTHER ATTENDING DENTIST/ FACILITIES IN THE FUTURE.**

_____ _____

Please print name of Patient Please sign for Patient/Guardian of Patient

_____ _____

Legal Representative/ Guardian Relationship of Legal Representative/Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ FIRST NAME ONLY ☐ PROPER SIR NAME ☐ OTHER: _____

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:**

- ☐ Text message to my cell phone (#) _____
- ☐ Email Confirmation _____

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text message to my cell phone (#) _____
- ☐ Email Confirmation (address) _____
- ☐ Any of the Above

I AUTHORIZE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION** ON BEHALF OF THIS DENTAL FACILITY VIA:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email _____
- ☐ Any of the Above
- ☐ None 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 remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.