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

ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this acknowledgment I authorize you to use and disclose my protected health information to carry out: treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. insurance company); and in the day-to-day healthcare operations of your practice. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. You may refuse to sign this acknowledgement and authorization. In refusing we *may not be allowed* to process your insurance claims.

_________________________________ _________________________________

Patient Name (Print) Patient/Legal Representative Signature

Date: ______________________ _________________________________

Legal Representative Relationship

RELEASE

My signature will also serve as consent to release my information should I request treatment or radiographs be sent to another doctor/facility in the future. Please list any other parties who can have access to your health information:

Name: _____________________________ Relationship: _______________________________

Name: _____________________________ Relationship: _______________________________

CONTACT AUTHORIZATION

Our office continually strives to increase convenience for our patients and improve communications. Accordingly, we would like to communicate with you via telephone, e-mail, and text messaging. The undersigned authorizes contact from this office to communicate information about appointments, treatment, billing, and special services**.**

_________________________________ _________________________________

Patient Name (Print) Patient/Legal Representative Signature

Date: ______________________ _________________________________

Legal Representative Relationship

Office Use Only

I attempted to obtain the patient's (or representatives) 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 because other (please describe) _______________________________________

Signature of Privacy Officer _____________________________