HIPPA OMNIBUS RULE – MATTHEW J. CIELINSKI, DMD
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign the acknowledgement & authorization. In refusing we may not be allowed to process your 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 SERVE AS A PHI (protected health information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.**

______________________________ ______________________________
Please PRINT name of Patient Please SIGN (Patient or Guardian of patient)

______________________________ ______________________________
Please PRINT (Legal Representative/Guardian) Relationship of legal Representative/Guardian

How would you like to be addressed when called from the reception area:

❑ First Name Only

❑ 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 patients records)

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

I authorize contact from this office to confirm my appointments via:

❑ Cell phone confirmation
❑ Home phone confirmation
❑ Work phone confirmation
❑ Email confirmation
❑ Text message to my cell phone
❑ It is okay to leave a voice mail at home
❑ It is okay to leave a voice mail at work
❑ **ANY OF THE ABOVE**

I authorize information about my health, treatment & billing information be conveyed via:

❑ Cell phone
❑ Home phone
❑ Work
❑ Text message to my cell phone
❑ Email
❑ **ANY OF THE ABOVE**

Please update your contact information:

Cell #: ______________________________

Home#: ______________________________

Work#: ______________________________

Email: ______________________________

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
❑ 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: ______________________________