

**PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF
PRIVACY PRACTICES CONSENT**

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

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND 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 & BILLING INFORMATION** VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the Above (opt out) |
| <input type="checkbox"/> Email | |

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 DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITY'S IN THE FUTURE.

Please **print** name of Patient

Please **sign** Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- | | | |
|---|--|---|
| <input type="checkbox"/> It was emergency treatment | <input type="checkbox"/> The patient refused to sign | <input type="checkbox"/> The patient was unable to sign because |
| <input type="checkbox"/> I could not communicate with the patient | <input type="checkbox"/> Other (please describe) | |

Signature of Privacy Officer