edwards&schaefer ORTHODONTICS

HIPAA Omnibus Rule

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & 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 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/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 parents, (if patient is over age 18) step parents, grandparents and any care takers who can have access to this patient's information/records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS & BILLING**

- Phone/Text Confirmation #_____
- Email Confirmation _____

I AUTHORIZE MY CHILD'S FIRST NAME & PHOTO TO BE POSTED FOR CONTEST WINNERS:

_____

SIGNATURE (PARENT OR GUARDIAN)

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.