HIPAA OMNIBUS RULE

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

You may refuse to sign the acknowledgment & authorization. In refusing we may not be permitted to process your insurance claim.

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 document release should I request treatment or radiographs be sent to other attending doctor/facility's in the future.

________________________________ ________________________________

Patient signature (Patient or Guardian) Patient Name (Please Print)

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 record):

Name: __________________________ Relationship: _______________________

Name: __________________________ Relationship: _______________________

Name: __________________________ Relationship: _______________________

Name: __________________________ Relationship: _______________________