



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.

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 RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** your name

Please **sign** your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or Consents:

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

First Name Only Proper Sir Name 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 patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation Text Message to my Cell Phone
 Home Phone Confirmation Work Phone Confirmation **Any of the Above**

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

- Cell Phone Confirmation Text Message to my Cell Phone
 Home Phone Confirmation Work Phone Confirmation **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:

- Phone Message **Any of the Above**
 Text Message **None of the above** (opt out)
 Email

(please read and sign the back of this form)

I have received a copy and understand Doshier Physical Therapy Associates (herein after "DPTA") Notice of Information Practices. I understand DPTA may use or disclose my personal health information (herein after "PHI") for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my PHI is used and disclosed if I notify the practice. I also understand that DPTA will consider requests for restriction on a case by case basis, but does not have to agree to requests or restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in DPTA Notice of Information Practices. I understand I retain the right to revoke this consent by notifying the practice in writing at any time. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Patient Signature or Guardian if a minor

Date

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