**Dr. M. Jean Kay and Dr. Brent Paulus**
**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 **Sign** Patient over 18 or Guardian Relationship

Your comments regarding Acknowledgements or Consents: _____

WE WILL CONTACT YOU VIA ALL OF THE CONTACT INFORMATION YOU HAVE PROVIDED ON THE CHART UNLESS YOU LIST

OTHERWISE HERE: _____

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: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**WEB AND SOCIAL MEDIA RELEASE**

I, _____ (**Parent/Guardian**) give my permission to have _____ (**Patient's Name**)'s photographs posted within our dental practice and/or on our bulletin board, website, social media accounts or educational slide show presentations.

_____
**Parent/Guardian Signature or over 18 years/Patient Signature**

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.

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**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

*HIPAA made EASY™*
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