Thomas family dental associates

Notice of Privacy Practices Acknowledgement

I, _____ (print name), acknowledge the 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. I understand that I may refuse to sign this acknowledgement.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

I authorize the following individuals (example; spouse, parent/grandparent, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care, and that if no individuals are listed, we will NOT share any information regarding your account.

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

I authorize information about my health to be communicated to me via:

❏ All of the following are acceptable
❏ Text message to my cell phone
❏ Email confirmation
❏ Cell phone confirmation
❏ Home phone confirmation
❏ Work phone confirmation

In signing this HIPAA Acknowledgement Form, I acknowledge and authorize, that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPAA Omnibus Rule, will provide me with this information with my knowledge and consent.

_____

Signature *Date*

For Office Use Only

As Privacy Officer, I attempted to obtain patient's (or representative's) written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____

_____

Privacy Officer Name / Date: _____