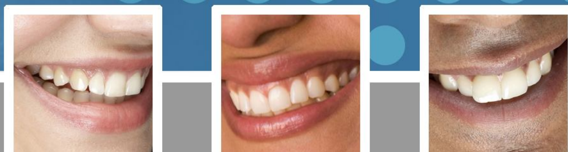
David M. Shabluk, D.D.S., P.C.
706 W. Randall
Coopersville, MI 49404

(616)837-6521

www.coopersvilledental.com



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

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Please sign for Patient/Guardian

Signature: ______________________________ Date: ____________

Your comments regarding Acknowledgements or Consents:

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION AND THEIR RELATIONSHIP WITH PATIENT:

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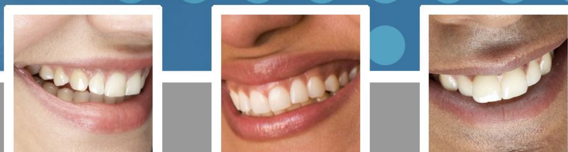

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS & COMMUNICATE TREATMENT INFORMATION VIA:

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

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- [ ] Cell Phone Confirmation
- [ ] Home Phone Confirmation
- [ ] Work Phone Confirmation
- [ ] Text Message to my Cell Phone
- [ ] Email Confirmation
- [ ] Any of the Above

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.

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)

Response Date: __________