

**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 / FACILITY'S IN THE FUTURE.**

\_\_\_\_\_  
Please **print** your name

\_\_\_\_\_  
Please **sign** your name

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

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

- |                           |                                 |
|---------------------------|---------------------------------|
| D Cell Phone Confirmation | D Text Message to my Cell Phone |
| D Home Phone Confirmation | D Email Confirmation            |
| D Work Phone Confirmation | D <b>Any of the Above</b>       |

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

- |                           |                                 |
|---------------------------|---------------------------------|
| D Cell Phone Confirmation | D Text Message to my Cell Phone |
| D Home Phone Confirmation | D Email Confirmation            |
| D Work Phone Confirmation | D <b>Any of the Above</b>       |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Phone Message | D <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | D <b>None of the above</b> (opt out) |
| <input type="checkbox"/> Email         |                                      |

Center One Dental Associates

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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