Lyons Family Dentistry

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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

Today's Date __________

The undersigned acknowledge a copy of a currently effective Notice of Privacy Practices for this healthccare facilty. A copy of this signed, dated document shall be as effective as the original

☐ **My signature or checkbox acknowledgement will also serve as a PHI document release should I request treatment or radiographs be sent to another attending doctor/ facility in the future**

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians: (example: John Doe (212-555-1212)

____

____

Your Name:

____

____

Legal Representative and Description of Authority

____

____

How do you want to be addressed when summoned from our reception area?

☐ First Name ☐ Proper Sir Name ☐ Other

Other: ________________

Please list any other parties who can have access to your health information (This includes stepparents, grandparents, and any care takers who can have access to this patient's records):

____

____

I authorize contact from this office to confirm my appointments, treatment & billing information via:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ Text Message to my Cell PJHone

☐ 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 PJHone

☐ Email Confirmation ☐ ANY OF THE ABOVE

I approve being contacted about Special

Services, Events, Fund Raising Efforts, and New Health Info on behalf of the Healthcare Facility via:

- ○ Cell Phone Confirmation
- ○ Home Phone Confirmation
- ○ Work Phone Confirmation
- ○ Text Message to my Cell PJHone
- ○ Email Confirmation
- ○ ANY OF THE ABOVE

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may reccomend products or services to promote your improved health. This office may or may not receive third party renumeration from these affliated companies. We, under current HIPAA Omnibus Rule provide you this information with your knowledge and consent.

☐

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Name of the person completing this form: *

____

Relationship to the patient: * ____________________

Response Date: __________