HIPAA OMNIBUS RULE

PATIENT ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Broad Ripple Family Dental. A copy of the signed and dated document shall be as effective as the original.

MY SIGNATURE ALSO SERVES AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO ANOTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

Print Name of Patient: _____

Print Patient's Guardian Name and Relationship if applicable: _____

Signature of Patient or Patient's Guardian: _____

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PLEASE CHECK A BOX BELOW:

I authorize contact from Broad Ripple Family Dental to confirm my appointments, treatment, billing information, and information about my health via:

- ☐ Cell Phone / Text Message to Cell Phone
- ☐ Home Phone
- ☐ Email
- ☐ Any of the Above

In signing this HIPAA Acknowledgment Form, you acknowledge and authorize that Broad Ripple Family Dental may recommend products or services to promote your dental health. Our office may or may not receive third party remuneration from these affiliated companies. We operate under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.