Joseph Roberto DDS and Traci A. Roberto DDS, PLLC
531 Moe Road
Clifton Park, NY 12065
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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES 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 / FACILITIES IN THE FUTURE.**

_____________________________________ _____________________________________

Please *print* name of Patient — Please *sign* Patient / Guardian of Patient

_____________________________________ _____________________________________

Legal Representative / Guardian — Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other ______________________

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND 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:

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

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

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

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

- ❑ Phone Message
- ❑ Text Message
- ❑ Email
- ❑ **Any of the Above**
- ❑ **None of the Above** (opt out)

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.

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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____