HIPAA OMNIBUS RULES
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement and 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 WIILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT INFORMATION BE SENT TO OTHER ATTENDING DOCTOR OR FACILITY IN THE FUTURE.

_____ _____

Printed name Signature Date

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: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE THIS OFFICE TO CONTACT ME VIA CELL, HOME OR WORK PHONE, EMAIL MESSAGE OR U.S. MAIL TO RELAY TREATMENT INFORMATION, BILLING INFORMATION OR INFORMATION ABOUT MY HEALTH. INTIAL: _____

IF YOU PREFER THAT WE DO NOT CONTACT YOU, PLEASE OPT OUT BELOW: ( ) Cell Phone/ Text ( ) Work Phone ( ) Home Phone ( ) Email Message ( ) U.S. Mail ( ) Opt out all of the above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize 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. If we receive any remuneration, we, under current HIPAA Omnibus Rule, will provide you with this information and obtain your consent first.

The privacy of your health information is important to Dr. Swartz and his staff. We will maintain the privacy of your health information. We consult with other therapists within this facility as well as ancillary staff, in order to provide you with optimum treatment plans, handle any crisis situations that are beyond the normal business day, as well as facilitate your appointments and insurance filing and payment. Each member of this treatment team is bound by a code of ethics within their individual licensure or their employment contract. Please feel free to discuss this with your therapist if you have any questions or concerns.

I understand and agree to the privacy practices implemented by Dr. Swartz as stated above.

_____ _____

Signature Date

_____

Printed Name

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 _____

_____ _____

Signature of Privacy Officer Date