ORAL SURGERY ASSOCIATES
OF CHARLOTTE

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, please note that we may not be permitted to process your insurance claims)

Date: _____

The undersigned acknowledges receipt of Oral Surgery Associates of Charlotte's currently effective *Notice of Privacy Practices*. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE SERVES AS A RELEASE FOR PROTECTED HEALTH INFORMATION (PHI) DOCUMENTS, SHOULD I REQUEST TREATMENT, RADIOGRAPHS OR ANY OTHER RECORDS BE SENT TO ANOTHER ATTENDING DOCTOR / FACILITY IN THE FUTURE.

_____ _____
Patient First & Last Name (*printed*) Patient Signature

_____ _____
Patient Legal Representative/Guardian Name (*printed*) Representative/Guardian Relationship to Patient

Comments regarding Acknowledgement / Consent (*optional*): _____

_____

HOW SHOULD THE PATIENT BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other: _____

PLEASE LIST ANY OTHER PARTIES WHO MAY BE GIVEN ACCESS TO THE PATIENT'S HEALTH INFORMATION:
(Such as stepparents, grandparents or other caregivers who may be given access to the patient's records, or who may accompany the patient to appointments)

First & Last Name (*printed*): _____ Relationship to Patient: _____

First & Last Name (*printed*): _____ Relationship to Patient: _____

I AUTHORIZE CONTACT FROM THIS FACILITY TO **CONFIRM PATIENT APPOINTMENTS** VIA:

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

I AUTHORIZE **INFORMATION ABOUT PATIENT HEALTH, TREATMENT & BILLING** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE CONTACT REGARDING **SPECIAL SERVICES, EVENTS, FUNDRAISING EFFORTS or NEW HEALTHCARE INFORMATION** ON BEHALF OF THIS FACILITY VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**
☐ **None of the Above** (*opt out*)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this facility may recommend products or services to promote your improved health. This facility may or may not receive third-party remuneration from any affiliated companies. We, under the current HIPAA Omnibus Rule, provide you with this information with your knowledge and consent.

Office Use Only

As Privacy Officer of this facility, attempts to obtain the patient (or representative) signature on this Acknowledgement were unsuccessful because:

☐ Emergency Treatment
☐ Unable to communicate with patient
☐ Patient Refusal
☐ Patient Unable to Sign (please describe): _____
☐ Other (please describe): _____

Signature of Privacy Officer:
_____