shea
WOMEN'S CARE
OBSTETRICS AND GYNECOLOGY
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.

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 / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

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

☐ First Name Only ☐ Last Name Only ☐ Other _____

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: _____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health record
_____ Physical exams only
_____ Immunization record
_____ Other (please specify): _____
_____ Lab results/X-ray reports
_____ Consultation reports
_____ Billing/Statement balances and details

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the practice.

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS & BILLING INFORMATION** VIA:

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

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

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

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, or NEW HEALTH INFO** (i.e. flu shot clinics, new patient services) for Shea Women's Care via:

☐ Phone Message ☐ Email ☐ Any of the Above ☐ None of the above (opt out)

All authorizations above will remain in effect until revoked in writing by the patient.
Thank you for helping us comply with the newest healthcare laws! If ever you have any questions or concerns, please let us know!

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 Date