Lymphatic USA™

315-760-4118
LymphaticUSA.com

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 they were given the opportunity to read and/or receive 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 DOCTORS / FACILITIES IN THE FUTURE.**

_____ _____

Printed name — please *sign* your name

_____ _____

Legal Representative — Description of Authority

Your comments regarding Acknowledgement or consent:_____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes significant others, step parents, grandparents, and any care takers who can have access to the patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENT, TREATMENT &BILLING INFORMATION** 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 MY HEALTH** BE CONVEYED VIA:

- ☐ Cell phone confirmation
- ☐ Home phone confirmation
- ☐ Work phone confirmation
- ☐ Text message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, EVENT PICTURES ON FACEBOOK, IN OFFICE AND ON THE WEBSITE, 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 with this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on the 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) _____

File#

_____
Signature of Privacy Officer