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

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your Insurance claims.
You Will Be Addressed by Your First Name Only When Summoned From Reception Area

Please List Any Other Parties Who Are Actively Involved In Your Health Care And Who Can Have Access To Your Health Information and records (*This includes spouse, partner, parent, grandparent and any care takers who can have access to patient's*) :

Name: _____ **Relationship:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENT & BILLING INFORMATION, MY PHI (PROTECTED HEALTH INFORMATION) BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Email Confirmation ☐ Text Message to my Cell Phone

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

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I authorize the use of email without password protection, unencrypted via Google and/or Microsoft for the purpose of any communication and transfer of PHI (protected health information).

I authorize the use of my email address and personal home address (that appears on my patient information form) for delivering of my dental, medical and financial records.

I allow transfer of my medical records and PHI to Dental Specialists, Healthcare Providers and Dental Insurance companies directly involved in my healthcare.

SMS text messages can be sent to the cell phone number on file, but no limited to information regarding my appointment confirmations, insurance confirmations, specialist & laboratory referrals, billing information and all medical correspondences.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

The undersigned acknowledges receipt of a copy of the currently effective ***Notice of Privacy Policy*** for ***Dr. Arthur Kezian's Dental office*** and ***Larchmont Dental Associates*** office. 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/Facility In The Future.**

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Print Name of Patient or Legal Guardian **Date**

_____ _____
Signature of Privacy Officer (Office Manager: Narine Tashjian) **Date**