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.

TODAY'S 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 PROTECTED HEALTH INFORMATION (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

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____

PRINT NAME SIGN NAME

____

____

LEGAL REPRESENTATIVE DESCRIPTION OF AUTHORITY

Your comments regarding Acknowledgements and Consents:____

____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION

(may include parents, stepparents, siblings, grandparents, caretakers, legal representatives, facilities, etc.)

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NAME RELATIONSHIP

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NAME RELATIONSHIP

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NAME RELATIONSHIP

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT AND BILLING INFO.**

Billing Information: Cell phone Home phone Work phone Facility Email Other ____________________

Health information: Cell phone Home phone Work phone Facility Email Other ____________________

Special Service, Events, Fundraising Efforts, New Health Information on behalf of this Healthcare facility: Cell phone Home phone Work phone Facility Email Other ____________________

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 this information with your knowledge and consent.

HIPAA OMNIBUS RULE P.2

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize Agave Surgical Associates and its affiliates (Provider) to release my medical records to any referring or referred physician and my primary care. I understand that the information in my health records my include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I further agree to physician orders and associated diagnoses being sent via fax or electronic submission, to other physicians, hospital pharmacies and/or other diagnostic/treatment facilities. I authorize payment under my medical insurance program to be made directly to Agave Surgical Associates and I further authorize Agave Surgical Associates to release to my medical insurance company any confidential medical information which may be considered instrumental and payment of my medical claim.

PATIENTS SIGNATURE: ____ DATE: ____________________

OFFICE USE ONLY As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

_____ Emergency Treatment
_____ Could not communicate with Patient
_____ Patient refused to sign

_____ Patient unable to sign
_____ Other (describe):
Signature of Privacy Officer __________________