HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

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

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

PLEASE CIRCLE YOUR PREFERRED METHOD OF COMMUNICATION:

Home Phone **Cell Phone** **Text Message** **Email**

Can we leave automated appointment reminders on your home or cell phone? Yes or No

Can we leave messages letting you know your glasses and contacts are ready? Yes or No?

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 DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please *print* patient's name **Please *sign* patient's name**

_____ _____

Legal Guardian **Date**