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: _____ **Account Number: _____**

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 SERVICE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE or CONSENT FOR DATA TO BE EXCHANGED ELECTRONICALLY BETWEEN PROVIDERS/HOSPITALS**

_____ _____

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

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgement or Consents

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

_____ First Name Only _____ Proper Sur Name 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 _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION and INFORMATION ABOUT MY HEALTH** VIA

Choose Only One Point of Contact

Home Telephone Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only

Cell Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only
_____ OK to send a text with detailed information

Work Telephone Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave a message with call back numbers only

Office Use Only

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 ___
- Other (please describe) _____

Signature of TSC Staff Member _____