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 SHOUL 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

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 _____________________________________________________________