CAROLINA
SMILE DESIGN

SUBMIT FORM

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.

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 PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please print name of Patient Signature of Patient or Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

Date: _____

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: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- ◯ Cell Phone Confirmation
- ◯ Text Message to my Cell Phone
- ◯ Home Phone Confirmation
- ◯ Email Confirmation
- ◯ Work Phone Confirmation
- ◯ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- ◯ Cell Phone Confirmation
- ◯ Text Message to my Cell Phone
- ◯ Home Phone Confirmation
- ◯ Email Confirmation
- ◯ Work Phone Confirmation
- ◯ Any of the Above

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.