BETHANY DENTAL ASSOCIATES
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HIPAA OMNIBUS RULE - PATIENT ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR BETHANY DENTAL ASSOCIATES

You may refuse to sign this acknowledgement. In refusing to sign this acknowledgement, we will not be allowed to process your insurance claims (HIPAA Title II).

Date _____

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for Bethany Dental Associates. A copy of this signed, dated acknowledgement shall be as effective as the original.

My signature will also serve as a PHI (protected health information) document release should I request documents be sent to other attending doctors/treatment facilities in the future.

_____ _____
Print Name Signature

_____ _____
Print child/children Name Signature

_____ _____
Legal Representative Description of Authority

Please list any other parties who can have access to your healthcare information: (This includes any caretakers, children, step-parents, grandparents, etc. who can have access to this patient's records):

_____ _____
Name Relationship

_____ _____
Name Relationship

I authorize information about my healthcare be conveyed via:

- ◯ Cell Phone Confirmation
- ◯ Home Phone Confirmation
- ◯ Work Phone Confirmation
- ◯ Email Confirmation
- ◯ **All of the Above**

In signing this HIPAA OMNIBUS RULE - PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR BETHANY DENTAL ASSOCIATES, you acknowledge and authorize that we may recommend products or services to promote your improved health. Bethany Dental Associates may or may not receive third party remuneration from these affiliated companies. We, under the current HIPAA OMNIBUS RULE, provide you this information with your knowledge and consent.