ARMSTRONG-ROOT OPTICIANS
649 SUN VALLEY ROAD, KETCHUM, ID 83340
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.

Date: _____

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.

X_____   X_____
Please _**print**_ name of Patient   Please _**sign**_ for Patient / Guardian of Patient

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

Your comments regarding Acknowledgements or Consents: _____
_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only   ☐ Proper Surname   ☐ 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: _____   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**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message   ☐ **Any of the Above**
☐ Text Message   ☐ **None of the above** (opt out)
☐ Email

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.

Office Use Only
As Privacy Officer, 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 because   _____
Other (please describe)   ____   _____
                                                          Signature of Privacy Officer