KIEU M. LE, D.D.S..PLLC

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM.

You may refuse to sign this acknowledgment and authorization. In refusing we may not be allowed to process your insurance claims.

DATE _____

The undersigned acknowledges receipt of a copy of currently effective NOTICE OF PRIVACY PRACTICES for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. I authorize contact from this office to CONFIRM MY APPOINTMENTS, TREATMENT OR ANY BILLING QUESTIONS OR FOR ANY INFORMATION WICH MAY BE NEEDED BY THIS OFFICE.

PATIENT NAME_____
(Print)

Signature of
PATIENT/PARENT/GUARDIAN_____
If signing as GUARDIAN-LEGAL DESCRIPTION OF AUTHORITY

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION AND/OR CONTACT IN CASE OF EMERGENCIES
(This can include step-parent, grandparents and/or any caretakers who can have access to this Patient's records)

NAME_____ Relationship_____
PHONE_____ or E-mail_____
Cell/Other_____

NAME_____ Relationship_____
PHONE_____ or E-Mail_____
Cell/Other_____