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.

In signing this HIPAA Patient Acknowledgement Form, I consent to allow Jackson and Lujan to summon me from the reception area by calling out my first and last name. If I prefer to be addressed differently, I will inform a technician so that he/she can place an alert in my file with this request.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO MY 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: _____

Name: _____ Relationship: _____

By sharing my Cell phone, Home phone, Address, Work phone and/or email, I am giving Jackson and Lujan Eyecare permission to contact me via one of these methods to relay information concerning my glasses or contacts, special services or events, new health information, appointment and yearly exam reminders. These contact methods may also be used to relay treatment information, billing information or information about my health. If I do not wish to be contacted by one of these methods, I will not give that contact information to Jackson and Lujan Eyecare.

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 INFORMATION BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient/Guardian of Patient

_____ _____

Legal Representative/ Guardian Relationship of Legal Representative/Guardian

Date: _____

Your comments regarding Acknowledgements or Consents: _____

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. If we receive any remuneration, we, under current HIPAA Omnibus Rule, will provide you with this information and obtain your consent first.

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 (please describe) _____

Signature of Privacy Officer _____