

**Dr. Adriana Porter, D.M.D.**

**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.**

\_\_\_\_\_  
**Patient Name (Print)**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Legal Representative/Guardian (Print)**

\_\_\_\_\_  
**Legal Representative / Guardian Signature**

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 \_\_\_\_\_

**IN THE EVENT OF AN EMERGENCY, 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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

**I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:**

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the above (opt out)</b> |
| <input type="checkbox"/> 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