CMB FAMILY DENTISTRY
HIPPA OMNIBUS RULE

Patient Acknowledgement of Receipt of Notice of Privacy Practices
And Consent/Limited Authorization & Release Form.

Date: _____
The undersigned acknowledges receipt of a copy or read the current effective Notice of Privacy Practices for CMB Family Dentistry. 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.

_____ _____ _____ ___
Please **print** name of Patient Date of Birth Please **sign** for Patient/Guardian of patient

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

How Do You Want To Be Addressed When Summoned From The Reception Area?
□ First Name Only □ Proper Sir Name □ Other

By Signing My Signature Below, I Hereby Authorize the Disclosure of My Protected Health Information (including HIV/Aids related information, if any)
Please List Any Other Parties Who Can Have Access To Your Health Information:

Name: _____ Relationship: _____

Name_____ Relationship: _____

Patient Signature: _____ Date: _____

Please provide your cell and email for appointment confirmations.

Cell#_____ Email_____
Home Phone (only for no cell or email capabilities) _____

By Signing below, I hereby authorize the practice to leave my protected health information (including but not limited to appointments, treatment, payments/financial responsibilities, prescriptions) on my answering device via text /email or mail letters/postcards with the above information to my home.

Patient Signature: _____ Date: _____

I Have Received/Read the HIPPA Notice of Privacy Practices Initials: _____***
This Authorization Does Not Expire Unless Revoked in Writing by the Patient