

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
for PHARMACY

You may refuse to sign this acknowledgement but, in refusing we
will 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 pharmacy, _____. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST DOCUMENTS BE SENT TO OTHER ATTENDING DOCTOR / TREATMENT FACILITIES IN THE FUTURE.**

Please **print** name of Patient

Patient, Please **sign** your name (if applicable)

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 Sur Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes and any care takers, step parents, grandparents who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE** 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"/> Any of the Above |

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

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

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this pharmacy may recommend products or services to promote your improved health. This pharmacy 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