Montgomery ENT Clinic
Montgomery Hearing Aid Specialists
Ohio Valley Surgical Arts
HIPAA 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 Montgomery ENT Clinic, Montgomery Hearing Aid Specialists, and or Ohio Valley Surgical Arts. 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 Records Be Sent to Other Physicians/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

By signing my signature below, I hereby authorize the disclosure of my Protected Health Information. Please list any parties who can have access to your Health Information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

I have Received/Read the HIPAA Notice of Privacy Practices. Initials: _____***
This authorization Does Not Expire Unless Revoked in Writing by the Patient

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For Office Use Only
As privacy officer, I attempted to obtain the patient's (or representative's) 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 _____**

_____
Signature of Privacy Officer