HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM FOR VISIONFIRST

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

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

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE CIRCLE YOUR PREFERRED METHOD OF COMMUNICATION:

Home Phone Cell Phone Text Message Email

Can we leave automated appointment reminders on your home or cell phone? Yes or No

Can we leave messages letting you know your glasses and contacts are ready? Yes or No?

Do you give Visionfirst permission to import your medications from NewCrop Rx? Yes or No
(NewCrop is a software we use to send in electronic prescriptions to your pharmacy.)

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 PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please *print* patient's name **Please *sign* patient's name**

_____ _____
Legal Guardian **Date**