CHATHAM DENTAL ARTS
587 OLD GRAHAM ROAD
PO BOX 582
PITTSBORO, NC
27312
EMAIL: INFO@CHATHAMDENTALARTS.COM
FAX: (919)542-5714
PHONE: (919)542-4911

HIPAA OMNIBUS RULE

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 of Practices for the healthcare facility; this is available to view at our front desk or online at www.chathamdentalarts.com.

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 **Please sign for Patient/Guardian of Patient**

_____ _____

Legal Representative/Guardian **Relationship of Legal Representative/Guardian**

Please list any other parties who can have access to your health information: (This includes Step Parents, Grandparents, and any Care Takers, etc.)

Name: _____ **Name: _____**

Name: _____ **Name: _____**