



Gaertner Psychiatric  
Adolescent & Adult Services

HIPAA OMNIBUS RULE

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM TO OBTAIN & RELEASE RECORDS AND  
CONSENT FORM TO DISCLOSE HEALTH INFORMATION & COORDINATION OF CARE**

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 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 PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT 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 \_\_\_\_\_

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only  Proper Surname  Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact PH # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact PH # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact PH # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact PH # \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Email Confirmation
- Work Phone Confirmation
- Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Email Confirmation
- Work Phone Confirmation
- Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office 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. I hereby request that health and mental health information may be discussed with and disclosed to the family member, relatives, school officials, friends and other providers, including therapists and physicians. The individual identified below are involved in my care and or payment of my care and agree that the provider listed above may share such information as the provider may deem relevant to such individual involvement. Including appointment times, required care and diagnosis. I understand that I have the right to revoke this request/ consent by delivering written notice to the provider.

This is for the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my primary care physician and or other mental health provider. I hereby authorize the use or disclosure of my individual identifiable health information. This release shall be valid until sixty (60) days after my last date of treatment or until I revoke this release.

**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) \_\_\_\_\_

HIPAA made EASY™  
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\_\_\_\_\_  
Signature of Privacy Officer