



ROBERT McLACHLAN JR. DDS MS **PALM DESERT DENTIST**
Cosmetic, Restorative & Implant Dentistry
Prosthodontist

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT FORM

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 OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

I, _____, have received a copy of this office's Notice Of Privacy Practices.

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

___ First name only ___ Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND 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 _____

Name _____ Relationship _____

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

- Cell Phone Confirmation
- Text message to my Cell Phone
- Home Phone Confirmation
- Email Confirmation
- Work Phone Confirmation
- Any of the Above

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

- Cell Phone Confirmation
- Text message to my Cell Phone
- Home Phone Confirmation
- Email Confirmation
- Work Phone Confirmation
- Any of the Above

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

- Phone Message
- Text Message
- Email
- Any of the Above
- None of the Above (opt out)

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.

Patient Information

First and Last Name _____

Email Address _____

Signature _____

Date _____