Sheo P. Sharma, MD

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM FOR SHEO P. SHARMA, MD

You may refuse to sign this acknowledgement & authorization.

Date: _____

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

(THIS INCLUDES YOUR SPOUSE, CHILDREN, STEP PARENTS, GRANDPARENTS AND ANY CARETAKERS WHO CAN HAVE ACCESS TO THIS PATIENTS' RECORDS)

NAME:_____RELATIONSHIP:_____ PHONE:_____

NAME:_____RELATIONSHIP:_____ PHONE:_____

NAME: _____RELATIONSHIP:_____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

HOW DO YOU WANT TO BE ADDRESS WHEN SUMMONED FROM THE RECEPTION AREA?

□ FIRST NAME ONLY □ LAST NAME ONLY □ OTHER _____

PLEASE CIRCLE YOUR PREFERRED METHOD OF COMMUNICATION:

HOME PHONE CELL PHONE TEXT MESSAGE EMAIL

CAN WE LEAVE AUTOMATED APPOINTMENT REMINDERS ON YOUR HOME PHONE OR CELL PHONE? YES NO

CAN WE LEAVE MESSAGES IN REFERENCE TO YOUR INSURANCE INFORMATION? YES NO

THE UNDERSIGNED ACKNOWLEDGES RECEIPT OF A COPY OF THE CURRENTLY EFFECTIVE NOTICE OF PRIVACY PRACTICES FOR SHEO P. SHARMA, MD. A COPY OF THIS SIGNED, DATED DOCUMENT SHALL BE EFFECTIVE AS THE ORIGINAL. MY SIGNATURE WILL ALSO SERVE AS PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITIES IN THE FUTURE.

_____

Please *print* patients name

_____

Please *sign* patients name

_____

Legal Guardian

_____

Date

_____

Witness