NAME:_____ DOB:_____

Gulf Coast Orthopedics: ACKNOWLEDGEMENT OF RECEIPT AND CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed,for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a courtesy you may list people below who you authorize access to your medical information pertaining to your treatment. You may revoke this authorization by contacting our office. We reserve the right to share information with family members or other persons, if in exercising professional judgment, we determine that doing so would be in the best interest of your patient care.

I authorize _____ , (relationship to patient: _____)
access to medical information pertaining to my treatment.

I authorize _____, (relationship to patient: _____)
access to medical information pertaining to my treatment.

I authorize _____, (relationship to patient: _____)
access to medical information pertaining to my treatment.

Signed: _____

This Consent was signed by: _____
Printed Name - Patient or Representative

Relationship to Patient (if other than patient): _____

Date: ____/____/____

front of _____
Printed Name - Practice Representative