

## Coastal Family Practice and Internal Medicine, LLC

1004 South Old Dixie Hwy, Suite #201, Jupiter, FL 33458

(Ph) 561-284-8383 (Fax) 561-284-8380

### HIPAA - HITECH POLICIES AND PROCEDURES

I acknowledge that I have been offered the practice Notice of Privacy Practices (“NoPP”) which discusses use of my personal information.

The NoPP explains how the practice may use and share my health information for purposes outside of general practice operations.

The practice will use and share my personal information as required/permitted by law.

I consent to the practice listed below using and disclosing practice data maintained by the practice for the purposes detailed in the NoPP.

Medical practice: Coastal Family Practice and Internal Medicine, LLC

Purposes for use of personal information: Medical Records/Billing/Other

Patient’s Complete Legal Name – PRINT \_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

**OR**

Authorized Agent\*: \_\_\_\_\_

\*May be requested to show proof of representative status.

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Your medical information will be required to be disclosed by law in certain circumstances such as for billing and in case of emergency. If you wish to keep your medical information from being disclosed to insurance carriers, you can pay for your services in full when rendered.

**Right to Request Confidential Contacts:** You have the right to request that this office contact you about medical issues in a specific manner outside of normal practice, such as by postal mail. You must specify how and where you wish to be contacted and we'll try to accommodate any reasonable requests.

**Right to a Copy of this Notice:** You have the right to a paper or electronic copy of this notice, which is available in our office and on the website—[www.coastalfamilypractice.health](http://www.coastalfamilypractice.health).

**Changes to this Notice:** this office reserves the right to change this notice and to make the revised notice effective for health information this office created or received about you prior to the revision, as well as to information it receives in the future. Revised notices will be available at the office and the above website.

**Complaints:** If you believe your privacy rights have been violated, you may file a complain with this office's Privacy Official or with the Secretary of the Department of Health and Human Services, office of Civil Rights.

Print Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the following individual(s) to receive information regarding my care (if desired):

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_