Gulf Coast Medical Center
NCQA Recognized Patient-Centered Medical Home

# Notice of Privacy Practices and Consent for Use of PHI

**Patient Name** _____ **Date** _____

**Date of Birth** _____ **Phone Number (Home/Cell)** _____ **Account Number** _____

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

**I understand** that Gulf Coast Medical Center may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Gulf Coast Medical Center has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the *'Notice'* before signing this agreement. If I ask, Gulf Coast Medical Center will provide me with the most current *Notice of Privacy Practices*.

**My signature** below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Gulf Coast Medical Center to use and disclose my protected health care information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Gulf Coast Medical Center has taken action relying on this consent.

List any other individuals authorized to have access to your medical records:

_____

_____

Do you reside in a SNF (Skilled Nursing Facility)? **YES** **or** **NO** Facility: _____

Do we have permission to release medical information to this facility? **YES** **or** **NO**

Do we have permission to leave a voicemail message? **YES** **or** **NO**

I consent to receive calls from Gulf Coast Medical Center for my protected healthcare and other services at the phone number(s) listed above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

**Signature** (Patient or Legal Custodian/Authorized Representative) _____ **Date** _____

**Relationship to Patient** if signed by another party _____ **Date** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our 'Notice' at any time by going to our website: www.gcmc1.com, asking the receptionist or calling 727-868-2151 and requesting a copy be sent to you.

11528 US 19, Port Richey, FL 34668
9238 US 19, Port Richey, FL 34668
11034/6 Spring Hill Dr., Spring Hill, FL 34608-5048
727-868-2151
*Privacy Officers:*
Lori Brienza, RN, LHRM, CCS-P
Tina Strobbe, RN, MBA, LHRM

  