MedFlorida
Medical Centers

Notice of Privacy Practices Acknowledgment

I understand that, under the health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- ✓ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by MedFlorida Medical Centers of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review in office or online at www.medflorida.com, such Notice of Privacy Practices prior to signing this consent. I understand that Medical Consultants of Florida has the right to change the Notice of Privacy Practices from time to time and that I may contact this office at any time by phone or in person to obtain a current copy of the Notice of Privacy Practices at: 3889 Military Trail, Suite 101 | Jupiter, Florida 33458.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in Acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented:
Date:_____
Initials:_____
Reason:_____