7855 38th Ave N, Suite 200, St. Petersburg, FL 3310 | 727-490-7729

HIPAA FORM

Patient Name: _____ DOB: ____/____/_____

Phone: _____-_____-_____ Email: _____

ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY POLICY AND PRACTICES

Optional Communication Methods: I understand the below methods of communication are unsecure communication platforms and potentially accessible by others. Gulf Coast Family Wellness shall not be held liable for any breach of confidentiality resulting from use of email, text, messages, or information that is lost or misdirected due to technical errors or failures.

Please initial to indicate YES or NO for the following options:

OK TO SEND EMAIL: YES _____ / NO _____

OK TO LEAVE VOICE MESSAGE: YES _____ / NO _____

OK TO SEND TEXT MESSAGE: YES _____ / NO _____

*To Opt-In, Text START to 727-490-7729 from your mobile device.
*You agree to receive recurring messages from GCF Wellness.
*Reply STOP to opt out; Reply HELP for help; Message frequency varies.
*Message and data rates may apply.
*Carriers are not liable for delayed or undelivered messages.

PRIVACY CONSENT

I have reviewed and understand my privacy rights. If I do not sign this consent, I may be declined treatment. With my consent, any medical provider at Gulf Coast Family Wellness may use and disclose my PHI (protected health information) to carry out treatment, payment and healthcare operations. This includes HIV/AIDS, alcohol/drug abuse and mental health records. I understand a written copy will be provided to me at any time upon my request.

Printed Name of Patient/Representative: _____

Signature: _____ Date: ____/____/_____