# HIPPA

| Patient Name | DOB | SS# |
|---|---|---|
| | | |

_____I acknowledge that information about me will be stored in an electronic medical record.

_____I acknowledge that if I am a patient at Emerald Coast Family Medicine, Emerald Coast Family Medicine may access information about me for purposes of treatment, payment, and healthcare operations.

_____I understand that I have the right to request that you restrict how information about me is used or disclosed for treatment, payment, or healthcare operations. I understand that you are not required to agree to these restrictions, but if you do, you are bound by the restrictions.

_____I acknowledge that I have been given the Emerald Coast Family Medicine Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

_____Furthermore I understand that a photocopy of this consent shall be considered as valid as the original.

Patient (or Responsible Party) Signature Date

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Emerald Coast Family Medicine.