



Gulf Coast ENT and Allergy Notice of Privacy Practices

This is a summary of the Notice of Privacy Practices, which describes how we may disclose your medical and personal information and how you can have access to this information. We have attached a full version of the notice.

Our Pledge to Protect your Privacy

We are committed to protecting the privacy of your medical and personal information. So we can best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your health information for any other purpose without your permission.

Your Rights Regarding your Medical Information

- To inspect and obtain a copy of your medical records with certain limitations.
- To request an amendment or addendum to your medical record.
- To an accounting of disclosures of your medical information.
- To request restrictions on certain uses and disclosures of your medical information.
- To request when and where to contact you.
- To request a copy of the full version of this document.

We may use and disclose your personal and health information without your authorization for the following purposes

- To provide you with medical treatment.
- To bill and receive payment for the treatment received, as required and permitted by law.
- For functions necessary to assure that our patients receive quality care.
- For public health activities (e.g. reporting abuse).
- To the coroner, medical examiner, funeral director or organ procurement organization for certain purposes, as required and permitted by law.
- To a court or administrative order, subpoena, discovery request or other lawful process.
- To a health oversight agency, such as the Department of Health Services.

We reserve the right to change our privacy practices and update this notice accordingly.

I have read and understand my rights to and of the above stated Privacy Standards.

Signature of Patient or legal Representative

Date

If Legal Representative, Indicate relationship to patient