

# Premier Urgent Care

## Badolato Family Health at Suntree / Viera

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### ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 my follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Obtain payment from third party payers.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Private Practices*.

Patient Name: \_\_\_\_\_

Name of Person authorized to receive information on patient's medical record:

Self Only

Other \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient:  Self  Parent/Guardian  Other \_\_\_\_\_

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I also understand Florida Law requires specific authorization regarding the release of any super confidential protected health information (specifically any protected health information regarding HIV/AIDS, Mental Health, Substance Abuse, or Reportable STDs). I give my authorization to this organization to release any super confidential protected health information to:

- Conduct, plan and direct my treatment and my follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Person(s) listed above as authorized to receive information on my behalf.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient:  Self  Parent/Guardian  Other \_\_\_\_\_

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