

**Premier Urgent Care  
Badolato Family Health at Suntree / Viera**

David W. Badolato, MD Stephen K. Badolato, MD Yvette Lopez-Granberry, MD Frank J. Listello, MD  
Nancy Baker, MD Christopher Galloway, MD Sarajane Sengel, PA-C

**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 Personal authorized to receive information on patient’s medical record:

Self (Only)

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

**Signature:** \_\_\_\_\_

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 STD’s). 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 \_\_\_\_\_

**6300 N Wickham Rd., Suite 101 Melbourne, FL 32940**

**Office (321) 253-2169**

**Fax (321) 253-1720**