Gulf Coast Physician Partners, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of gulf coast physician partners' (the "Practice") Notice of Privacy Practices (the "notice"). The notice contains information regarding potential uses and disclosures of my protected health information(as the term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA") that may be made by my practice, and of my rights and practices legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

Initial_____

Authorization to pay benefits to the Physician

I hereby authorize the office of Gulf Coast Physician Partners P.A. for any serviced furnished to me by trial physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Initial _____

Medicare Patients Authorization

I request that payment of authorized Medicare benefits be made either to me on my behalf to Gulf Coast Physician Partners P.A., for any services furnished to me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Initial _____

_____ _____

Date Signature of Parent and/or guardian, if patient is a minor