GULF COAST PYSICIAN PARTNERS, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I will be provided with a copy of Gulf Coast Physician Partners" (the "practice") Notice of Privacy Practices (the "notice") if I so desire. This 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 "HIPAA") that may be made by the practice, and of my rights and practices legal duties with respect to my protected health information. I have 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. to receive payment for any services 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 to me or on my behalf to Gulf Coast Physician Partners P.A. (GCPP) for any services furnished to me. In addition, I authorize GCPP to release to the Health Care Administration and its agents any information needed to determine these benefits payable for related services.

Initial_____

Patient Signature-or if a minor-Signature of Parent or Legal Guardian

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Date______________________