Gateway Medical

Privacy Policy

Gateway Medical, LLC is committed to safeguarding your privacy and we value the trust our clients place in us with their families.

Any personally identifiable information provided to us will be used only to send you requested communications about our services. We never have and never will share any visitor information (including your email address) with any third party. Our website provides the capability to request information online. To process your request, we may require that you provide us with personal identifying information. We may request the personally identifiable information identified above from users on online orders. This information is used for billing purposes and to fill customer's orders. If we have trouble processing an order, personally identifiable information is used to get in touch with the user. All information collected is held in complete confidence.

We strive to make sure that all information presented on our website is accurate and as up-to-date as possible. For your convenience, we may provide links to third parties' websites but we are not responsible for the content or functionality of those websites or the privacy policies of those third parties. Our privacy policy no longer applies when you link to a different website. We have policies and safeguards in place to ensure your privacy. Gateway Medical is also required by state and federal laws to protect the confidentiality of your health information.

We are dedicated to protecting our client's privacy and protecting their health information, in accordance with recent Federal HIPAA legislation. Please contact us if you have any questions or concerns. All information provided on this website is subject to change without notice. Thank you for your patronage. We look forward to serving you.

To report a privacy incident, please visit: https://www.gatewaycares.com/privacy-policy
To send us a secure email, please visit: https://gatewaycares.secureemailportal.com

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PATIENT SIGNATURE

I have read this policy and all of my questions about my privacy have been answered. By signing below, I acknowledge that I have read and accept all of the above:

Signature of Patient or Personal Representative	Date	Signature of Witness	Date
Print Name of Patient/Personal Representative	Date	Print Name of Witness	Date

CONTACT INFORMATION

The contact information for the patient or personal representative who signed this form should be filled-in below:

Street Address	City/State/Zip	Daytime Phone
Street Address	City/State/Zip	Evening Phone

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