Notification of Information Practices

The purpose of the consent form is to inform you, the patient, how your personal health information is used &/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, & allow administrative & other types of health care operations to happen, which are part of normal business activities of the provider.

Your consent

I understand that as part of my health care, Health Depot DME originates & maintains health records describing my health history, symptoms, test results, diagnoses, treatment, & plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care & treatment.
- A means of communication among my diagnosis & other health information to my bill.
- A source of information for applying my diagnosis & other health information to my bill.
- A means by which my health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations Health Depot DME, such as ensuring that we have quality processes & programs in place & making sure that the professionals who provide your care are competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples & descriptions of how my personal health information is used & disclosed by Health Depot DME;
- I have the right to review the Notice of Information Practices prior to signing this consent;
- Health Depot DME, Inc. can change its Notice of Information Practices but notifies me of those changes before they are put into practice & will mail me a copy of the new Notice to the address that I have provided;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations & that Health Depot DME, Inc. is not required to agree to those restrictions;
- Any restrictions to which Health Depot DME, Inc. agrees to will be respected;
- I may revoke this consent in writing at any time. Further, I am aware that Health Depot DME, Inc. can proceed with uses & disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use & discloser of your personal health information related to your treatment, payment for service, or for the health care operations of Health Depot DME, Inc., please do so after reading the Notice of Information Practices. You may use this consent form to request a restriction.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

For Provider Use Only:	
Restriction is:	**Patient is notified?**
☐ Accepted	☐ Yes
☐Denied	☐ No

Please provide your signature below to indicate that you have read the above consent & have reviewed the Notice of Information Practices.

_____ _____

Signature of Patient or Legal Representative Witness

_____ _____

Date Effective Date