

Notification of Information Practices

The purpose of the consent form is to inform you, the patient, how your personal health information is used and/or disclosed by **Spectrum Diabetic Services**. 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, and allow administrative and other types of health care operations to happen, which are part of normal business activities of the provider or organization.

Your consent

I understand that as part of my health care, **Spectrum Diabetic Services** originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among my diagnosis/es and other health information to my bill(s).
- A source of information for applying my diagnosis/es and other health information to my bill(s).
- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care and competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and discloses by **Spectrum Diabetic Services, LLC**;
- I have the right to review the Notice of Information Practices prior to signing this consent;
- **Spectrum Diabetic Services, LLC** can change its Notice of Information Practices but notify me of those changes before they are put into practice and 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 and that **Spectrum Diabetic Services, LLC** is not required to agree to those restrictions;
- Any restrictions to which **Spectrum Diabetic Services, LLC** agrees to will be respected.
- I may revoke this consent in writing at any time. Further, I am aware that **Spectrum Diabetic Services, LLC** can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use and disclose of your personal health information related to your treatment, payment for service, or for the health care operations of **Spectrum Diabetic Services, LLC**, 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

- Accepted
 Denied

Reason denied:

Patient is notified?

- Yes
 No

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

Signature of Patient or Legal Representative / Date

Witness / Date