



Phone: 407-849-6455 | Fax: 407-849-6458

Orlando
915 S Orange Ave
Orlando, FL 32806

Altamonte Springs
614 E Altamonte Dr
Altamonte Springs, FL 32701

Kissimmee
1113 N Central Ave
Kissimmee, FL 34741

Lady Lake
724 S US HWY 441
Lady Lake, FL 32159

Protected Health Information Privacy Agreement

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

DATE: _____

I authorize Florida Home Medical Supply, Inc. dba Colonial Medical Supplies to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations. *

* **Treatment** (includes activities performed by a health care provider, practitioner, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between our health care providers. This consent includes treatment provided by any health care provider who covers my/our facility by telephone as the on-call provider.)

* **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.)

* **Health Care Operations** (including the necessary administrative and business functions of our office.) You may review Colonial Medical Supplies' "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our store indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions of how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other providers who provide on-call coverage for our store are required to use and disclose your protected health information consistent with the Notice.

Name someone authorized by you to handle your account should you be unable to do so. You must print neatly.

Name _____ Name _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Relationship _____ Relationship _____

Phone # _____ Phone # _____

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Colonial Medical Supplies has already used or disclosed the information in reliance on this Consent.

Signature of Patient