AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

My health records are private and are covered as "Protected Health Information" (PHI) under the Health Insurance Portability and Accountability Act ("HIPAA"), as well as applicable state privacy laws. By completing and signing this form, I, or my legal representative, hereby authorize the use and disclosure of my PHI by PriceMDs.com, Inc. (together with its subsidiaries, affiliates, employees, agents, subcontractors and representatives, "PriceMDs") as described below, and I agree to allow PriceMDs to share my PHI with the individuals and/or companies listed below.

I understand and acknowledge that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent the delivery of healthcare services, unless the provisioning of healthcare services would otherwise require the sharing of your PHI with the parties identified below, or eligibility for benefits under a health plan. I understand that I am entitled to receive a copy of this form upon signing it. I understand that if the organization or individual authorized to receive my PHI is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. I understand that the information being disclosed may be subject for redisclosure. I understand that I have a right to revoke the authorization I've granted hereunder, but that to do so, I will be required to send a written revocation request to **nursing@pricemds.com** or to the PriceMDs mailing address below. I also understand that revocations shall only apply prospectively, and not reactively (i.e. that such revocation applies to usesand disclosures made after the revocation is made).

Patient/Member Information:

Patient Name		DOB	Case #
Address	City	State	Zip

Physician or organization authorized to release my PHI ("Discloser"):

Physician Name		Phone Number	Fax
Address	City	State	Zip

Person or organization authorized to receive my PHI ("Recipient"):

PriceMDs.com, Inc./ Business Associates of PriceMDs inclusive of Physicians, Nurses, Office Personnel Medical Providers, Pharmacist, Pharmaceutical Suppliers and Distributors, Concierge Service /Freight Forwarders/ U.S. Customs/ FDA/USDA, and Third-Party Medical Record Retrieval Services (Health Gorilla)	**PriceMDs** Phone Number and Fax Number: Phone: 813-818-4531 Fax: 813-219-1965 or 813-344-0422

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PriceMDs.com Address	City	State	Zip
19321 US 19 N Building C Suite 509	Clearwater	FL	33764

Discloser can share ONLY my records chosen below for the purpose of consult and/or other services:

☐ Any information requested
☒ Health (medical, dental, pharmacy, vision, and flexible spending account information)
Include H&P, active prescriptions, and lab work: CBC/CMP/TB/HepB panel from the previous 2 years
☐ Disability ☐ Life insurance ☐ Long term care ☐ Patient management records

Sensitive Information (which can only include diagnosis and/or treatment information):
☐ Substance use disorder (alcohol/drug) ☐HIV/AIDS ☐ Sexually transmitted diseases
☐ Behavioral health/Mental health (but NOT psychotherapy notes).
☐ Other (please explain): _____

Unencrypted Text Message and Email Alerts Preference

PriceMDs.com, Inc. ("PriceMDs") offers helpful administrative information and alerts by email and regular text message. As with any form of unencrypted communication, there is a risk of compromised information sharing. It is important that we confirm your consent for sending / receiving unencrypted communications containing your private health information with PriceMDs internal team members. Based on the options below, please indicate your choice(s):

☐ **Yes**, I am comfortable sending / receiving unencrypted email communications regarding my private health information from the PriceMDs team.
Please confirm your email address:

☐ **Yes**, I am comfortable sending / receiving unencrypted text messages regarding my private health information with the PriceMDs team.
Please confirm your cell phone number:

☐ **No**; I am not comfortable sending/receiving unencrypted email communications regarding my private health information.

☐ **No**; I am not comfortable sending/receiving unencrypted text messages regarding my private health information.

Telemedicine Consent is below

My authorization is valid from_____or until patient is no longer participating in Plan's offering.

Patient Signature

Patient Signature	Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

If signed by a patient representative:

Representative Name (print)	Relationship to Patient and Authority Status (partner, legal guardian, Power of Attorney, personal representative).
Representative Signature	

- If this request is being signed by the member's legal representative, you must provide legal documentation authorizing you to act on the patient's behalf (e.g., legal guardianship, power of attorney, personal representative).
- If you are making this request on behalf of a minor child, you may be required to provide additional information before this request is considered complete.

PriceMDs.com, Inc. complies with all applicable State and Federal laws and does not unlawfully discriminate, exclude, or treat people differently based on their race, color, national origin, sex, age, or disability.

If you have a concern, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W. Room 509F, HHH Building, Washington, DC 20201, or at: 1-800-368-1019, 800-537-7697 (TDD).

Informed Consent for Telemedicine Services

Introduction:

I understand that Telemedicine involves the use of electronic information and communication technologies by healthcare providers when located at different locations from the patient being treated to deliver services and share individual patient medical information, otherwise known as "Protected Health Information" ("PHI") under the Health Insurance Portability and Accountability Act ("HIPAA"), for the purpose of improving such patient's care and remote monitoring. Healthcare providers may include primary care practitioners, specialists, and/or subspecialists, and I hereby consent to PriceMDs.com, Inc. (together with its subsidiaries, affiliates, employees, agents, subcontractors and representatives, "PriceMDs") providing health care services to the undersigned patient via telemedicine.

Purpose: During the telemedicine consultation the information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records and details of the patient medical history
- Medical images
- A physical examination may take place and any x-rays or lab results will be discussed with patient and with other health professionals using any combination of interactive, live, two-way audio and video communications with the patient
- A non-medical technician may be in attendance to aid in the telemedicine technology.
- Output data from medical devices and audio and video files, and photo recordings may be taken of the patient during the procedures or examinations.

Electronic systems used for the purposes of transmitting such PHI will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard such PHI and to ensure its integrity against corruption, loss or damage.

By signing this form, I understand and consent to the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand my insurance carrier may have access to these medical records for quality review/audit.
3. I understand that I will be responsible for any applicable copayments, deductibles or coinsurances that apply to the telemedicine visit under the health plan I have indicated for coverage.
4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment or coverage under any specific healthcare benefits plan. I may revoke this consent verbally or in writing at any time by contacting PriceMDs at 813-818-4531. If this consent is in force (has not been revoked) PriceMDs may provide health care services to the patient via telemedicine without the need for executing another consent form.
5. I understand that I have the right to inspect all of my PHI obtained and recorded in the course of a telemedicine interaction and may receive copies of such PHI in exchange for a reasonable fee.
6. I understand that the level of care provided by a provider providing care remotely is to be the same level of care that is available through an in-person visit. I also understand that the provider may determine that a telemedicine consultation is not appropriate for some or all of patient's treatment needs. If this is the case, the provider may require the patient to schedule and attend an in-person visit instead.
7. I understand that a variety of methods of medical care alternative to telemedicine may be available to me, and that I may choose one or more of these alternatives at any time, upon written notice thereof to such healthcare provider.
8. I understand that telemedicine may involve electronic communication of my PHI to other medical practitioners who may be located in other areas, including out of my State of residence and out of the United States of America.
9. I understand that it is my duty to inform PriceMDs.com, Inc. of electronic interactions regarding my care that I may have with other healthcare providers.
10. I understand that I should seek emergency help or follow-up care when recommended by the telemedicine provider or when otherwise needed, and to continue to consult with my primary care physician and other health care professionals as recommended.
11. I understand that although I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured by PriceMDs.com, Inc. or any other healthcare providers. Furthermore, I understand that, as with any health care services, there are potential risks associated with the provision of care via telemedicine. These risks include, but may not be limited to:

a. In rare cases, information transmitted regarding your physical condition may not be sufficient (e.g., poor resolution of images) to allow for appropriate health care decision making by the provider.

b. Delays in evaluation or treatment could occur due to failures of the telecommunications systems or equipment. If this happens, you may be contacted by phone or other means of communication.

c. In rare cases, a lack of access to all your health records may result in adverse drug interactions or allergic reactions or other judgment errors.

d. Although the electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information, in rare instances, security protocols could fail, causing a breach of privacy of personal health information.

TCC PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, and all questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care and to share my medication information, including my PHI, with those individuals and entities involved in my treatment, including without limitation, PriceMDs.com, Inc.

I hereby authorize each of the physicians, person, or organizations (recipients) identified in the *Authorization to Receive PHI* to use telemedicine during my treatment.

Name of Patient:

Signature of Patient:

Date:

Minor patient (under 18 years of age):

Signature of Person Authorized to Sign for Patient:

Relationship of Authorized Signer to Patient:

I have been offered a copy of this consent form (initials):