AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORAMTION

DocsConnect, LLC, 1101 N. Lake Destiny Rd., Suite 300, Maitland, FL, 32751, USA

This authorization allows DocsConnect LLC ("DocsConnect") to use and disclose certain protected health information ("PHI") as I have directed. I understand:

1. The information specified below may include mental health, substance abuse, HIV/AIDS status, diagnostic and treatment records.
2. This authorization may be used to share the same type of information that is created in the future until the expiration date.
3. I may revoke this authorization at any time by notifying the company's Privacy Designee in writing, but my revocation does not affect any disclosure made prior to the revocation being received and processed, and does not affect information that is otherwise permitted to be disclosed by law without my specific authorization.
4. The information disclosed may no longer be protected by federal or state privacy laws and could be re-disclosed by the person that receives it.
5. I am signing this form voluntarily. Signing this authorization is not a condition for continued treatment, payment, enrollment in a health plan, or eligibility for benefits.
6. Unless revoked, this authorization will expire upon the following date, event or condition: _____ [if left blank, then 1 year the date signed].
7. I must complete the entire form, sign it, and provide appropriate verification of identity (for example, drivers license, State-issued ID, passport), and if filing this in a representative capacity, I must provide documentation proving my legal authority to request this information (for example, a power of attorney, guardianship paper, health care surrogate form, custody order, order appointing personal representative, letters of administration).

Patient's Legal Name: _____ Date of Birth:_____

Address:_____ Last 4 of SSN [Optional]:_____

City:_____ State:_____ Zip:_____ Country:_____

Phone:_____ DocsConnect Username:_____ Email Address [Optional]:_____

Authority to authorize: (Check the appropriate box)

☐I am the patient. Describe and attach a form of verification of identity :_____

☐I represent the patient. Relationship to patient:_____ Describe legal authority:_____

Describe and attach a form of verification of identity: Describe and attach a form of verification of authority:

_____ _____

By signing this form, I authorize the release of PHI as follows:

Obtain from the doctor, office, facility or other health care provider as either or both checked to the right or written below: ☐DocsConnect LLC

Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Country:_____

Phone:_____ Fax: _____ Attention to:_____

Send to the doctor, office, facility, health care provider, or person written below:

Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Country:_____

Phone:_____ Fax:_____ Attention to:_____

Method of Sending Records:

☐Paper (I understand all records will be mailed unless specified) ☐Email address (via secured server) – Email address to send information must be provided:_____ ☐Electronic

The purpose of this request:

☐Personal Use ☐Treatment ☐Payment & Billing ☐Legal Purposes ☐Disability Determination ☐School ☐Employment

☐Other: _____

Select the information to be disclosed: **List any specific dates needed:**_____

☐Abstract of Record (Dictated reports, laboratory, cardiology, radiology reports) ☐Treatment and Problem Notes ☐Emergency Physician Sheet

☐Discharge Summary ☐Operative Record ☐History & Physical

☐Laboratory and Pathology Reports ☐Billing Records ☐Medication List

☐Radiology Images and Reports ☐Occupational, Physical, and Speech Therapy

☐**Mental Health, Psychiatric Treatment** ☐**Alcohol or Substance Abuse Treatment** ☐**Sexually Transmitted Disease, HIV/AIDS Treatments or Tests;** ☐**Genetic Testing**

☐Other:_____

Patient Signature / Patient Representative Signature: **Print Patient Name:**

_____ _____

Print Patient Representative's Title:

Date: _____ _____

Witness signature [Optional]: **Print Witness Name:**

_____ _____

Date:_____