PATIENT CONSENT AND AUTHORIZATION FORM

(Please Read and Sign)

I, _____, hereby consent and authorize Activate Healthcare, PC to provide me with the services listed on the attached description of Activate Services. In the provision of Activate Services, I consent and authorize Activate Healthcare, PC to provide:

- Administration and performance of all relevant diagnoses and treatments
- Performance of such procedures as may be deemed necessary or advisable in my treatment
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended.

I understand that **ACTIVATE HEALTHCARE, PC** may rely upon this Patient Consent and Authorization Form at satellite offices under common ownership and services provided in support of Activate Healthcare, PC by its manager Activate Healthcare, LLC.

I, the undersigned, authorize **ACTIVATE HEALTHCARE, PC** to use, receive and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. Specifically, by executing this Consent and Authorization Form I knowingly authorize and intend to permit Activate Healthcare PC to use and release protected health information to other healthcare providers and to my health plan as necessary, and to permit other healthcare providers and my health plan to release the necessary protected health information to Activate Healthcare, PC, as necessary for Treatment, Payment and Healthcare Operations.

This authorization is valid twelve months from the below date.
A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given the **ACTIVATE HEALTHCARE, PC** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Officer.

I certify that I have read and fully understand the above statements, consent and authorization fully and voluntarily to its contents.

Printed Patient Name Date of Birth

Patient Signature Date of Signature

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HIPAA COMMUNICATIONS AND DISCLOSURES AUTHORIZATION

The federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH") a subpart of the American Recovery and Reinvestment Act of 2009 ("ARRA") and the implementing regulations regarding the privacy and security of individually identifiable health information (45 CFR Parts 160 and 164) communicated therein (collectively, the "Laws") require patient authorization for certain uses of such patient's individually identifiable health information ("Protected Health Information" or "PHI"). While the Laws permit, generally, the use and disclosure of PHI for treatment, payment and operations, Activate Healthcare, PC requests formal authorization from each patient to enable its legitimate use of PHI, in all cases.

I,_____,
authorize **ACTIVATE HEALTHCARE, PC** to receive, use and/or disclose my Protected Health Information for the purposes of Treatment, Payment, and Healthcare operations as described in the Notice of Privacy Practices.

Specifically, by signing this Authorization Form I intend to permit Activate Healthcare PC to use and release my Protected Health Information to other third parties, healthcare providers and to my health plan as necessary for Treatment, Payment and Healthcare Operations under the Laws.

Moreover, I authorize other third parties, healthcare providers and my health plan to release my Protected Health Information to Activate Healthcare, PC, as necessary for Treatment, Payment and Healthcare Operations under the Laws.

I acknowledge and agree that Activate may use or disclose, as appropriate, any and all information in its possession, including information relating to any medical history, mental, behavioral or physical condition, including drug or alcohol conditions, and any diagnosis or treatment about or received by me.

Communication with Patient: I specifically authorize Activate to communicate with me using the confidential contact information provided below for that purpose and using Twine and other applications. I understand that Protected Health Information will only be communicated using secure means, such as Twine and the Activate Patient Portal.

Twine Messages: I understand that Activate provides an Activate Patient Portal and Twine application, both of which allow patients to input data, such as weight, blood sugar or blood pressure, and, using Twine, I may send **Non-Urgent** messages to my providers and Activate providers may send messages back to me.

I understand that Twine is **only** for **Non-Urgent** matters. I understand that Activate Providers do **not** have access to Twine except when they are in the Activate Clinic.

Activate Providers will attempt to respond to all Twine Messages and Alerts within two (2) business days. Activate Providers will only respond to Twine Messages and Alerts, and cannot otherwise monitor information provided by patients through Twine or the Activate Patient Portal.

Activate Providers cannot and **will not** respond to emergency or urgent messages, alerts or conditions, using Twine or the Activate Patient Portal.

If I have an emergency condition or an urgent problem, I will call 911 right away.

Further, following this authorization, I authorize any uses or disclosures not mentioned in this document but otherwise required by law.

I acknowledge that I have been given the **ACTIVATE HEALTHCARE, PC** Notice of Privacy Practices. I understand that if I have questions or complaints about this Authorization or about the privacy practices of **Activate Healthcare, PC** that I should contact the Privacy Officer at privacy@activatehealthcare.com.

I certify that I have read and fully understand the Authorization fully, have had the opportunity to ask questions about it and voluntarily agree to its contents.

_____

Printed Patient Name | Date of Birth

_____

Patient Signature | Date of Signature

Confidential Contact Information.
Authorized personal (not work or shared) address, email and phone number for Confidential Communications with Patient:

Mailing Address: _____

Email Address: _____

Telephone Number: _____

Activate may__ / may not___ leave a telephone voice message using the telephone number provided.

_____

Signature of Patient's Representative (if for minor patient), Relationship to Patient | Date

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HIPAA Third Party Authorization

Patient Name: _____

Date of Birth: _____

Spouse, family members, or other persons involved in your care that can be given medical information about you by this office, or contacted in the event of an emergency.

A. _____ Relationship: _____

Phone Number(s): _____

B. _____ Relationship: _____

Phone Number(s): _____

C. _____ Relationship: _____

Phone Number(s): _____

D. _____ Relationship: _____

Phone Number(s): _____

E. Power of Attorney (POA) for Medical _____

Phone Number(s) of POA: _____

Limitation on Information: Please describe any information you do not want shared with anyone listed above. Please provide the name(s) and type of information.

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

This form will remain in effect from the date of the signature. Any changes to this form must be submitted on a new form by the patient.

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AUTHORIZATION FOR COMMUNICATION AND RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI

I hereby authorize the use and disclosure of my individually identifiable health information as described below. Activate Healthcare ("Activate") may use or disclose health information as set forth in this Authorization. I understand that this Authorization is voluntary. i understand that if the person or organization authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by federal privacy regulations and Activate cannot guarantee that the receiving person or entity will not re-disclose the information.

Persons/Organizations authorized to receive the information: _____

Information to be disclosed: Activate is authorized to disclose the following health information.

- My entire medical record that Activate has in its possession, including information relating to any medical history, mental, behavioral or physical condition, including drug or alcohol conditions, and any diagnosis or treatment about or received by me.
- All of my health information described above except for the following:
  _____
- Only the following records or types of health information (identify dates of treatment or other designation):
  _____

Specific purpose of the use or disclosure: _____

Communication with Patient: I specifically authorize Activate to communicate with me using the confidential contact information provided below for that purpose and using the Twine app. I understand that Protected Health Information will only be communicated using secure means, including Twine and the Activate Patient Portal.

Twine Messages: I understand that Twine allows patients to send Non-Urgent messages to their providers and allows Activate providers to send messages back to patients.
I understand that Twine is only for Non-Urgent matters. I understand that Activate Providers do not have access to Twine messages except when they are in the Activate Clinic and that Activate Providers will attempt to respond to all Twine Messages within two (2) business days.
Activate Providers cannot and will not respond to emergency or urgent messages using Twine. If I have an emergency condition or an urgent problem, I will call 911 right away.

Expiration date of authorization: This Authorization will remain in effect until Activate completes the request or for one year from the date of signature below.

Refusal to sign/Right to revoke: I understand that Activate will not condition treatment or eligibility for payment or benefits on my signing this Authorization. I understand that I may refuse to sign this Authorization for any reason. I understand that i may generally revoke this Authorization at any time by notifying the Activate Privacy Officer in writing at the address below, but the revocation will not have any effect on any actions that Activate took before it received the revocation.

Questions: Please direct questions regarding this Authorization or the privacy of your health information to the Activate Privacy Officer at privacy@activatehealthcare.com.

I understand my rights and authorize the use or disclosure of my individually identifiable health information as set forth in this Authorization.

_____ _____

Signature of Patient **Date**

Authorized Personal (not work or shared) Address, email and phone number for Confidential Communications with Patient:

_____

Activate may__/ may not __ leave a telephone voice message on the telephone number provided.

_____ _____

Signature of Patient's Representative Relationship to Patient and Date

Prescription Drug Information

Patient Name: _____

DOB: _____

A variety of prescription **generic drugs** are available to you for free at this location. You have the right to choose to fill your prescriptions at the pharmacy of your choice. If you would like to have your prescription sent to a local pharmacy or to a mail order service, simply let the Activate Healthcare team know your pharmacy's contact information. Please initial here to acknowledge your right to choose the pharmacy that will fill your prescriptions.

_____

Authorized friend/family member(s) that may pick up medications or paper prescriptions:

Print name of authorized person	**Print name of authorized person**