AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Last Name _____ First _____ MI_____

Date of Birth_____ Social Security Number:_____

Address_____
_____

Phone _____ Email _____

I hereby authorize:

Practice name_____

Address_____

Phone_____ Fax_____

To release my health information to

VECTOR Health, LLC
1267 N Steamboat Dr Ste 3
Fayetteville, AR 72704
P: 479-316-6565
F: 479-316-0331

Information to be released:

- ▢ Physical Exam/Notes
- ▢ Imaging/X-Rays/Labs Dates _____
- ▢ Procedures Dates _____
- ▢ STI Records Dates _____
  - ▢Including HIV related records* Dates _____
- ▢ Mental Health Records*
  - ▢Including psychotherapy notes Dates _____

or

▢ Entire Medical Record **with** ▢HIV records* ▢Mental Health records*

This authorization expires in one year or on the following date _____

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

*I understand that these records are considered especially sensitive and authorize them to be released to VECTOR Health & Wellness, LLC for use in determining ongoing treatment related to these conditions.

Patient Signature _____Date_____

Signature of any other consenting party_____Date _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, Vector Health & Wellness LLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any 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 the many health professionals who contribute to my care
- □ A source of information for applying my diagnosis and surgical information to my bill
- □ A means by which a third-party payer can verify that services billed were actually provided
- □ A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the medical practice reserves the right to change its notice and practices and before implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that 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 the medical practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the medical practice has already taken action in reliance thereon.

□ I request the following restrictions to the use or disclosure of my health information.

_____ _____

Signature of Patient or Legal Representative Date

□ Accepted □ Denied

_____ _____ _____

Signature Title Date

CONSENT FOR TELEMEDICINE SERVICES

Patient Name_____DOB _____ Date_____

Telemedicine is the use of electronic information and communication technology by a healthcare provider to deliver services when they are located at a different site than the patient. Insurances that cover telemedicine services often stipulate that the visit must be done by videoconference instead of just by telephone. I understand that some insurances do NOT cover telemedicine services under some, or any, circumstances.

The laws that protect privacy and confidentiality of medical information also apply to telemedicine and my insurance has the ability to request records for quality review or audit.

I am responsible for any copay, coinsurance and deductible and I agree to pay these costs the next time I am seen for an in-person visit or at the time I receive a billing statement for these services, whichever is sooner.

Though VECTOR Health & Wellness, LLC makes every effort to verify my insurance benefits and eligibility, it is my responsibility to make sure telemedicine is a covered benefit. If it is not, I have the option to pay for the telemedicine appointment out-of-pocket, reschedule for an in-person appointment at a later date or cancel my telemedicine appointment altogether. The missed appointment fee of $25 applies to both in-person and telemedicine appointments.

I have the right to withhold or withdraw my consent in the course of my care at any time without affecting my right to future care or treatment. I may revoke my consent verbally or in writing by contacting VECTOR Health & Wellness, LLC directly.

I understand that, like a regular in-person appointment, it is possible that my appointment may not start at the exact time that my appointment is scheduled. The clinic staff will call me if the provider will be more than 15 minutes late in sending me a link - either by text message or email. I also understand that once the provider sends the link, I have 10 minutes to respond to the link and set up the videoconference on my camera-enabled computer or device.

I understand that no video or audio recording of the visit will be retained and the documentation in the electronic medical record will be the only record of my telemedicine visit.

I understand that my computer or device must be located in a private area. My telemedicine visit must be conducted in an area free from interruptions where others cannot hear or see me. I understand that I have the option to include another person in the telemedicine visit. (For Minors only - I understand that I must accompany the minor for the telemedicine appointment unless prior arrangements have been made).

_____I consent to the use of Telemedicine as part of my medical care.
_____I DO NOT consent to the use of Telemedicine as part of my medical care.

Patient or Guardian Staff
Signature_____Signature_____Date_____