



## COMMUNICATIONS AND ELECTRONIC INTERFACES ACKNOWLEDGEMENT

### RECEIPT OF COMMUNICATIONS (MAIL/EMAIL/TEXT/SECURE PATIENT HEALTH PORTAL)

By providing a mailing address, email address and/or telephone number(s) and signing below, you are giving express written consent for **PHYSICIANS MEDICAL GROUP LLC** (the "Practice" or its affiliates, business partners, vendors, agents and others calling at their request or on their behalf) to contact you at these modes of communication, or any mode that is later provided by you and to leave live or pre-recorded messages or text messages regarding your upcoming appointments, medications, general health care needs or follow-ups, account or bill information related to any services received, patient education or marketing information. You confirm that any email address or phone number provided by you is associated with you as the individual authorized to receive such updates. For greater efficiency, calls may be delivered by an auto-dialer, and you understand and agree to any charges incurred related to the same. Consent to these terms is not a condition of services. You may opt out of these messages at any time.

### RISKS ASSOCIATED WITH ELECTRONIC COMMUNICATIONS

Standard text messages and unencrypted emails are not secure. The risks of using these forms of communication include possible interception by unauthorized parties, misdirected information, unauthorized disclosures via shared accounts, message forwarding, and storage of information on unsecured platforms and devices. The Practice does not recommend communicating about treatment or other sensitive information via unsecured email or standard text messaging. By sending electronic communications to the Practice by standard text messaging and/or email, I am giving permission for the Practice to respond to me using the same method in which I sent the communication.

The Practice may request that I submit my request to receive information in an unsecure fashion in writing, and I understand that I can ask the Practice at any time about secure communication platforms that can be used to receive health information. By signing this form, I agree to these terms and accept the risks to my protected health information should I choose to communicate with the Practice via standard text messaging or email or request that my protected health information be sent to me in this fashion.

### RECORDING PROHIBITED

I understand that recording audio or video at the Practice facility is not permitted due to the security and privacy risk it presents to other patients, visitors, and staff, except in rare circumstances. By signing below, I agree not to record your provider or encounter without the express permission of the Practice and its providers.

### DANGEROUS WEAPONS AND FIREARMS

The Practice prohibits carrying, possession or use of a firearm and/or dangerous weapon inside all affiliated facilities. This includes any item customarily considered a weapon, including but not limited to firearms of any type, explosives, electrical weapon (i.e., taser), knives or similar items with blades and any chemical whose purpose is to cause harm to another person. This policy is in place to provide a safe environment for our patients, visitors (including children and infants), vendors, employees, and healthcare providers. Exceptions: This policy does not prohibit use or possession of dangerous weapons or firearms by certified law enforcement officers acting within the scope of their employment.

### EXTERNAL PRESCRIPTION HISTORY

By executing this Consent, patient gives authorization for the Practice and affiliated providers to view your external prescription history via the RxHub service. Patient understands that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include past prescriptions for several years. This will allow your providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

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SIGNATURE of Patient/(or Authorized Representative) PRINTED Patient Name/Authorized Representative

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DATE



## HEALTH INFORMATION EXCHANGE CONSENT AND DISCLAIMER

(For compliance with standards of the US Department of Health and Human Services HIPAA Privacy and Security Rule)

**PHYSICIANS MEDICAL GROUP LLC** (the "Practice") is utilizing eClinicalWorks, which is an electronic health record system that grants the Practice access to Health Information Exchange(s) ("HIE") that make patient's protected health information ("PHI") securely accessible to a network of authorized participating health care providers, health care organizations, hospitals, laboratories, radiology centers and pharmacies ("HIE Participants"). This will allow the Practice, inclusive of its physicians, physician extenders, nurses, medical support staff and employees, access to your PHI from other medical providers who are also authorized HIE Participants to facilitate efficient and effective continuation of your medical care and treatment and to enable more efficient payment and health care operations in accordance with all allowable purposes under Florida law and federal law.

### DISCLAIMER REGARDING CONSENT TO AND PARTICIPATION IN THE HEALTH INFORMATION EXCHANGE ("HIE")

This Consent cannot and does not seek to transfer the care, the obligation to review, or the responsibility to act upon information contained in the medical records shared with the Practice from any other physicians or HIE Participants not affiliated with the Practice. The Consent to and use of HIE shall not be used to relay critical results or other urgent patient information nor will it be utilized as a substitute for the traditional methods of communication of urgent or critical patient results in a similar clinical context, and the physicians and other health care providers affiliated with the Practice expressly disavow any responsibility and/or liability related to the failure to communicate or review any critical, urgent or otherwise important information, data or results that may be communicated through the HIE rather than through the traditional methods of communication used in similar clinical contexts.

Any patient requests to have their physicians or other health care providers affiliated with the Practice to review or discuss information shared through HIE would constitute a request for input only and does not transfer the care or the medical decision-making from any other physicians or HIE Participants not affiliated with the Practice. The use of and/or transfer of information through the HIE by any physicians or HIE Participants shall not create or impose any obligation upon the physicians or other health care providers affiliated with the Practice to review, respond to, or act upon the data, information, or other results, critical or otherwise, contained in the medical records shared through the HIE system.

By executing this Consent, the patient expressly acknowledges and agrees to the foregoing and further recognizes that they maintain the sole responsibility for following orders rendered by any of their physicians or other health care providers related to their own health care, and further agrees that the Consent to share information through the HIE system does not substitute or replace the patient's sole responsibility to follow orders or instructions given by their physicians or other health care providers.

Your consent becomes effective upon signing this form and will remain in effect until revoked in writing with the Practice. You may revoke and/or change your consent status at any time by signing a new consent form with the Practice. Changes to your consent status may take up to 72 hours to become active in the system. Please note, however, that other HIE Participants may copy, include, or reference your PHI from the Practice in their own medical records. As such, even if you later decide to revoke your consent and/or change your consent status, other HIE participants will not be required to return and/or remove your PHI from their records.

By signing below, I hereby acknowledge that I am over eighteen (18) years of age; that I have read and understood this Consent and Disclaimer; that my questions regarding this Agreement have been answered; and that I have been given the choice to receive a copy of this Consent and Disclaimer.

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

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SIGNATURE of Patient/(or Authorized Representative) PRINTED Patient Name/Authorized Representative

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DATE