

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below for purposes other than payment, treatment and health care operations. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:

PHYSICIANS MEDICAL GROUP LLC

2. Persons/organizations authorized to receive the information:

Primary Partners, Aledade Florida Central ACO LLC, eClinicalWorks® Electronic Health eXchange(eHX) and integrated HIE's such as (Commonwell and Carequality)

3. Specific description of information that may be used/disclosed:

Electronic and non-electronic medical records and notations for care improvement coordination

Items 4-6 only apply if the practice is requesting the information for its own uses and disclosures.

4. **The information will be used/disclosed for the following purposes:**

Our practice works with Primary Partners and Aledade in care improvement coordination activities; see Primary Partners website for additional information at www.primarypartners.org; see Aledade website at www.Aledade.com

5. I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
6. The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes ☐ No ☒
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7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:

- (a) action has been taken in reliance on this authorization; or
- (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

9. This authorization expires on [upon] December 31, 2035

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or
authority to act for the patient