AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION & ACKNOWLEDGEMENT OF DISCLOSURE REFERRAL SERVICE INFORMATION

Patient Name: __________ **DOB**: ________ **Address**: ________________________ **Phone**: ____________

Section A: Use and Disclosure of Protected Health Information

I hereby voluntarily authorize OverbookMD ("Company") to use or disclose any medical information regarding my health status that I provide in my Patient Intake Form [attached hereto or provided below/above]**,** ("**Protected Health Information**" or "**PHI**"). I understand this authorization allows Company and its employees to disclose my PHI with the recipient of such information.

To Whom: I authorize Company to disclose my PHI to the following persons:

□ **Any and all physicians that have agreed to the terms and conditions necessary to be included in Company's physician referral platform ("Platform")**

Purpose: Please indicate the purpose of the use/disclosure of the PHI:

□ **Treatment Purposes**

Section B: Referral Service Disclosures

I acknowledge the receipt of the following disclosures:

1. The physicians who may provide services to patients as a result of those patients' use of the Company's Platform ("Physicians") have provided information to the Company including their areas of expertise and at least two (2) references from other physicians who have stated that they would use the participating Physicians for their own care.

2. All Physicians have represented to Company that they are compliant with the Texas Medical Board, and that all information they have provided to Company is and will continue to be accurate.

3. When you submit a care request though the Platform, Company will identify the Physicians to whom that request may be provided based on the relationship between those Physicians' skills and expertise and the type of requested care.

4. Company will attempt to match you with one of the Physicians based on the order in which a Physician accepts the care request. You acknowledge that the Company does not and cannot guarantee a match with a Physician.

5. Company does not employ the Physicians, or direct or control what services they may provide, including any medical services, and does not offer or provide preferential placement or recommendations for any one Physician over another.

6. Physicians do not pay the Company any fee for the ability to receive patient matches through the Platform.

7. Physicians continuing to be considered for receiving referrals from the Platform is conditioned on the information provided by those Physicians being and continuing to being accurate.

Section C: Rights and Signature (must be completed for all authorizations)

By signing below, I indicate that I understand the following:

1. The authorization to disclosure my PHI provided on my Patient Intake Form includes any information that I include concerning any Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV); psychiatric/psychological conditions and/or psychiatric/mental health treatment; and/or substance use disorder and/or treatment of substance use disorders.

2. Refusal to sign this authorization will prevent you from accessing OverbookMD's physician referral services.

3. Any PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected.

4. This authorization will expire within five (5) business days upon your signature and submission of this authorization.

I agree and understand that by signing below, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

____________________________________	____________________________
Patient's signature or patient's legally authorized representative's signature	**Date**

Printed name if patient's legally authorized representative:

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How are you legally authorized to be the patient's representative?

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