PRIMARY CARE SPECIALISTS OF FLORIDA
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ORLANDO, FL
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GENERAL SHARING OF HEALTH INFORMATION

I agree to Primary Care Specialists of Florida, LLC and it's Physicians using and sharing all my health information, including but not limited to highly confidential information, for payment, my continued treatment, and Health Care operations. This includes sharing my information with the following:

- All Physicians and other medical service provider associated with my treatment
- All business partners, who provide administrative, operational, Color Financial, legal and Technical Support Services
- All Insurance payers and healthcare plans responsible for paying or determining if I am eligible for payment for my treatment

SUBSTANCE, DRUG and ALCOHOL ABUSE AUTHORIZATION

I authorize Primary Care Specialists of Florida, LLC to release all my substance abuse and drug and alcohol abuse health information for my treatment, payment for my treatment, and the healthcare operations associated with my treatment. I understand this authorization may be canceled anytime unless Primary Care Physicians of Florida, LLC have already acted and relied on it, if not previously revoked. I understand this authorization is effective until I am deceased.

MESSAGES and MAIL

I understand you might communicate with me through the US mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, treating you follow up or to tell me about the services that are available. I understand that I must tell you if I don't want you to communicate with me like this.

SHARING HEALTH INFORMATION WITH FAMILY AND FRIENDS

I understand you will share my health information with family and friends or other individuals who are present with me unless I tell you otherwise.

TELEHEALTH

I understand Primary Care Specialists of Florida, LLC uses Telehealth tools to conduct evaluation and Management Services.

- I hereby authorize Primary Care Specialists of Florida, LLC to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
- I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
- I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
- I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
- I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.
- I agree that Telehealth services have several limitations over face-to-face visits, but during the COVID 19 pandemic may be necessary to protect my wellbeing and limit the spread of the virus.

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Patient Signature   Date