HIPAA Authorization to Disclose Protected Health Information

Member Name: _____ Date of birth: ____/____/____

I request, and hereby authorize, Teladoc Health, Inc., on behalf of Teladoc Physicians P.A. ("Teladoc"), to disclose protected health information ("PHI") about me to the following Recipient:

Name: _____ Telephone #: _____

Address: _____ Fax #: _____

Disclose PHI via: ☐ Mail ☐ Fax ☐ Verbally/Phone

INFORMATION TO BE RELEASED (Check all that apply)

	All behavioral health consult notes (including symptoms, medications prescribed, lab results, treatment plan, medical history)*		All general medical consult notes (including symptoms, medications prescribed, lab results, treatment plan, medical history)*
	Behavioral health consult notes (including symptoms, medications prescribed, treatment plan, medical history)* only for the following date(s):		General medical consult notes (including symptoms, medications prescribed, treatment plan, medical history)* only for the following date(s):
	All medical records collected and the Best Doctors Report for expert medical services obtained for the following purpose:		List of general medical and/or behavioral health consult dates of service including provider name
	Other (please specify):		Other (please specify):

***These notes include everything I said during the consult. Nothing will be redacted unless I specifically ask for something to be redacted. I wish to have Teladoc redact the following information from the records prior to disclosure: ☐ Mental Health ☐ Alcohol/Substance Abuse treatment ☐ Genetic Testing and family medical history ☐ AIDS/HIV treatment and testing ☐ Sexually Transmitted Disease (STDs) ☐ Sexual Abuse information**

The PHI will be used by the Recipient for the following purpose(s): _____

- I understand that once Teladoc discloses my PHI pursuant to this Authorization, Teladoc can no longer guarantee the confidentiality of my information because it is no longer under its control and might not be protected under HIPAA or other applicable law.
- I understand that I am not required to sign this Authorization and that Teladoc will not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I sign this Authorization.
- I understand this Authorization will expire one (1) year from the date I sign it. If I change my mind before that time and want Teladoc to stop sharing information as allowed by this Authorization, I can write a dated letter requesting this form be revoked, along with my dated signature, and send it to Privacy Officer, Teladoc Health, 2 Manhattanville Road, Suite 203, Purchase, NY 10577. If I revoke this Authorization, I understand it will not change any disclosures Teladoc made before I revoked the Authorization.
- I agree to keep a signed copy of this Authorization for my records.

_____ _____

Name of Member Date

_____ _____

Signature of Member or Legal Representative If applicable, name, type and proof of Legal Representation