1055 N. 500 W. Provo, UT. 84604
P| 801-429-8062 F| 801-374-2615

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION USING FollowMyHealth ™

Patient Name(s):_____DOB:_____
Proxy Name_____Phone:_____
Address:_____
City, State, Zip: _____
Proxy Email Address: (email address that the invitation will be sent to)_____

[ ] Full Access
[ ] View Only Access

Relationship to subject of information: [Place "x" in the appropriate box below]
[ ] Patient (12 years +)
[ ] Parent to Minor (under 12 years)
[ ] Guardian - documentation needed*
[ ] Other Legal Representative - documentation needed*
[ ] Other _____

By signing where indicated below, I hereby authorize:

Revere Health, on its own behalf and on behalf of: (1) all of its subsidiaries and otherwise affiliated entitiesfor which it has the authority to act or direct use or disclosure of its electronic health data; (2) each of their respective employees, independent contractors and agents; and (3) each of their respective employed or contracted health care providers, as applicable (collectively, "Revere Health"), to disclose the following information to the FollowMyHealth portal and its administrators and operators (except when disclosure is prohibited by applicable State law):

Any and all data and health information about me maintained by Revere Health, including but not limited to information related to the following types of records or information: billing and account statements, prescription drug information, secured e-mail transmissions between myself and Revere Health, and clinical testing and laboratory results, including but not limited, to genetic testing information, mental health treatment information (excluding psychotherapy notes), infectious disease information (including HIV status), medical research records of both open and closed trials (where applicable), information regarding mental, physical or sexual abuse; and substance abuse treatment information. Revere Health may, within its discretion, elect to withhold from disclosure any of the above information that contains particularly sensitive information.

I understand that the disclosure of HIV/AIDS-related records and information could have adverse consequences for me, including the loss or denial of employment, the loss or denial of health or life insurance benefits, alienation from friends and family members, and other forms of discriminatory treatment, whether lawful or unlawful.

I understand that I have the right to review my mental health records at any reasonable time prior to authorizing their disclosure.

I understand that my authorization includes the authorization to disclose any information or records (within the scope of the authorization) that Revere Health has received from other healthcare providers or facilities. The purpose of this authorization is to enable FollowMyHealth to maintain my personal health record on my behalf, subject to my control and direction.

This authorization shall expire upon (1) my termination of my FollowMyHealth account; (2) my removal of Revere Health as a health care provider with which I want to be connected on my FollowMyHealth account; or (3) 999 months from the date I sign and submit this authorization, whichever occurs first. I may terminate my FollowMyHealth Account or change the providers that submit information to my personal health record by following the directions on my FollowMyHealth account at any time. In addition, I can request assistance from FollowMyHealth in so doing by sending an email to customersupport@jardogs.com

By signing where indicated below, I acknowledge that:
I may revoke this Authorization at any time. Such revocation will promptly take effect except to the extent that Revere Health already has acted based on this Authorization. I may revoke this Authorization by removing of Revere Health as a health care provider with which I want to be connected on my FollowMyHealth account or providing my request to Revere Health. However, I acknowledge that data previously submitted by Revere Health as authorized by me prior to my subsequent revocation of this Authorization will remain in my FollowMyHealth account.

Revere Health cannot condition my access to treatment or services if I refuse to sign this Authorization. However, I further acknowledge that if I do not authorize Revere Health to provide my information as set forth herein to FollowMyHealth, it will not release my information to FollowMyHealth and I will have to manually input my information into my personal health record maintained on my FollowMyHealth account.

I have been informed that once my information is disclosed to FollowMyHealth, it will no longer be protected health information covered by the HIPAA Privacy Rule and may be subject to further disclosure, subject to applicable federal and state law with respect to re-disclosures of health information. Neither Jardogs nor Revere Health will be responsible for any re-disclosures allowed under my account password.

I understand that by participating in FollowMyHealth, there is a risk that my protected health information will be accessed without my consent through a data breach or other means. I understand that Revere Health is not responsible for my protected health information once that data is disclosed to FollowMyHealth pursuant to this authorization. I hereby release Revere Health, and its members, shareholders, partners, directors, officers, employees, and agents of any liability relating to services provided by FollowMyHealth and the unauthorized disclosure of my protected health information held by FollowMyHealth once it is disclosed to FollowMyHealth by Revere Health as authorized pursuant to this authorization.

Signature of Patient or Legal Representative(s): _____
(Note: If a minor child is granting access to a parent/guardian, minor child must sign)

Date:____/____/_____Printed Name(s): _____

Relationship to Patient: _____
(if signed by other than patient)

*Documentation needed: Power of Attorney, Living Will, Court Order, Affidavit, other supporting documentation.