V2

Patient Sortal® Health

PATIENT SORTAL
NEW MEMBER ENROLLMENT FORM

(Please fill out all blanks and submit completed form to your counselor or a reentry staff member)

First Name: _____ **Last Name**: _____

DOC Number: _____ **Date of Birth:** _____

State Located (ex. PA): _____ **Facility Name**: _____

Incarceration Date: _____ **Projected Release Date**: _____

Are you?: [ ] Max out [ ] Paroling [ ] Trying to Parole

Circle of Care: Please provide at least one family member, friend, or emergency contact we can reach if we lose contact with you post release to make sure you are connected with your care team.

Name: _____ **Relation:** _____ **Phone**: _____

Name: _____ **Relation:** _____ **Phone**: _____

How did you hear about us? _____

- ☐ I have read and accept the Privacy Policy (attached)
- ☐ I have read and accept the Terms of Service (attached)

Any additional questions at this time: _____

_____

Member Commitment:

I, _____ would like to become a Patient Sortal member, will call the Patient Sortal
(Print Name)
team upon release, and receive my healthcare services from Patient Sortal when coming home.

_____ _____
Signature Date

THANK YOU FOR BECOMING A MEMBER OF PATIENT SORTAL

We are excited to work with you!

Patient Sortal – Terms of Service

Patient Sortal Inc. (Patient Sortal) is a Healthcare Data Management company that manages protected health information (PHI) for clients, healthcare providers, businesses and other organizations that create, generate, share, or store protected health information. We focus on managing PHI during transitions in care as client's transition between providers. Patient Sortal Inc and its subsidiaries Patient Sortal Management Services, LLC and affiliates, Patient Sortal Health, PLLC assists clients by: (1) gathering and organizing personal medical information for easy access by clients and in transferring medical information to the clients' health care providers; (2) streamlining PHI sharing processes for organizations who provide levels of care such as but not limited to, intakes and referral services; (3) Care management to our clients to assist with appointment scheduling, identifying care providers and community resources, making referrals, assisting with insurance enrollment and management; (4) Internal Medicine / Primary Care Services (collectively, the "Services").

By engaging Patient Sortal, you agree to be bound by the terms and conditions of service stated herein and the terms provided on any purchase order, incorporated herein by reference. If you do not agree to all the terms and conditions stated herein, you might not use any services offered by Patient Sortal. You can review the most current version of the Terms of Service at any time at www.PatientSortal.com. Patient Sortal reserves the right to update or modify, in whole or in part, these Terms of Service by posting updates and/or changes to this website. It is your responsibility to check this website periodically for any such updates or modifications. Your continued use of Patient Sortal services constitutes your acceptance to any such updates or modifications.

Patient Sortal is not responsible if information, including, but not limited to, health care information, provided to Patient Sortal by you and/or any health care provider is not accurate, complete, or current. "Health care information" includes, but is not limited to, information that relates to past, present, or future physical or mental health conditions or the provision of health care services to an individual. To the extent you identify any concern regarding the accuracy of your information, you agree to raise such concern if the individual or entity responsible for the creation of such information.

Your submission and Patient Sortal receipt, storage, and transmission of personal information and health care information is governed by Patient Sortal's Privacy Policy, incorporated into these Terms of Service as if fully set forth herein . You may not use Patient Sortal services and/or the information gathered by Patient Sortal for any illegal or unauthorized purpose.

Patient Sortal does not guarantee, represent, or warrant that the Services will be error-free. Patient Sortal does not make any representation or warranty concerning the quality and/or appropriateness of the health care services provided by your health care providers. You expressly agree that your use of the Services is at your sole risk.

Patient Sortal does not recommend, comment on, or make decisions with respect to your healthcare and the services you may or may not receive from health care providers including Patient Sortal Health, PLLC. To the extent Patient Sortal provides the name of a health care provider that may be able to assist you, Patient Sortal provides such reference without endorsement or recommendation, and you agree that the selection of a particular health care provider is entirely your own and without influence by Patient Sortal.

In no case shall Patient Sortal, its owners, directors, officers, employees, or agents be liable for any injury, loss, claim, or any direct, indirect, incidental, punitive, lost revenue, loss of data, replacement costs, or any other damages of any kind, whether based in contract, tort, strict liability, or otherwise, arising from your use of the Services, including, but not limited to, any errors or omissions in any health care information stored or transmitted by Patient Sortal. In states that do not allow for the limitation of liability for certain damages, Patient Sortal liability shall be limited to the maximum extent allowed by such state law.

You agree to indemnify, defend, and hold harmless Patient Sortal and its owners, directors, officers, employees, or agents from any claim or demand, including a demand for attorneys' fees, made by any third party due to or arising out of your breach of the Terms of Service or any violation of law or the rights of a third party.

In the event any provision herein is determined to be unenforceable, such provision shall be enforceable to the fullest extent permitted by law. Such unenforceable provision shall be severed from the Terms of Service and shall have no effect on the enforceability of any other remaining provision herein.

These Terms of Service remain in effect until the Services are terminated by you or Patient Sortal. The obligations and liabilities of you and Patient Sortal that incurred prior to the termination date shall survive the termination of the Terms of Service .

The laws of the State of Delaware shall govern these Terms of Service. You and Patient Sortal agree to resolve any disputes relating to these Terms of Service in any court having jurisdiction in New Castle County, Delaware. You and Patient Sortal agree to waive the right to a trial by jury.

Patient Sortal – Privacy Policy

Patient Sortal Inc. (“Patient Sortal”) is Healthcare Data Management Company that assists individuals, healthcare professionals, business, and other organizations in the management of protected health information (PHI) during continuity of care and works with Patient Sortal Management Services, LLC to manage this care and Patient Sortal Health, PLLC to provide care. In order to assist individuals in the management of their PHI, Patient Sortal assists individuals in the collection, maintenance, and transmission of all of their health information as directed by the individual. Patient Sortal acknowledges the sensitive and private nature of PHI, and believes that securing and maintaining the confidentiality of this information is vital to Patient Sortal’s operations and its relationship with its clients. Although Patient Sortal strives to assure confidentiality, as set forth herein, Patient Sortal cannot guarantee that it will prevent every unauthorized use or disclosure of a client’s information. To achieve Patient’s Sortal’s goal to empower clients to manage and organize their health care information in order to make informed healthcare decisions, it is Patient Sortal’s commitment to maintain the privacy of its clients’ health information and to use and share such information only as directed by the client. This Privacy Policy explains how Patient Sortal collects information from its clients and their health care providers and how Patient Sortal uses that information subject to the clients’ directions.

The Information

Patient Sortal obtains medical records at a client’s direction pursuant to that client’s individual right of access to that information under applicable Federal law. That right of access allows the client to direct his/her healthcare providers to send information in the format requested (if the health care provider can produce it in that format) directly to Patient Sortal. This information will include all medical records, including, but not limited to, medical history, diagnoses, services provided, imaging and laboratory results, and the plan of care. It will also include demographic data, such as name, date of birth, address, and social security number.

Patient Sortal cannot guarantee that the information sent to Patient Sortal by a health care provider will be complete and accurate. It is the clients’ obligation to review the medical records created by their health care providers to ensure that the information is accurate and up-to-date. If the client identifies an issue with his or her information, the client has the right to address that issue with his or her health care provider.

Transmission of Information to Patient Sortal

Generally, Patient Sortal requests that a client’s health care provider work with Patient Sortal team members to set up best practices for sharing PHI with Patient Sortal and how to correctly obtain information from Patient Sortal. Processes vary for each client as safety and security standards are implemented before PHI is transferred between clients and Patient Sortal.

Storage of Information

When information is transmitted to Patient Sortal, it is stored under a client specific file in Patient Sortal’s cloud based, Blockchain backed, encrypted database and our Electronic Health Record. Only Patient Sortal employees have access to the database.

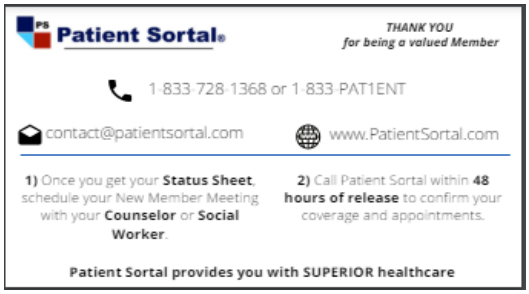
Transmission of Information

Any information managed on behalf of a client will be accessible with appropriate levels of security to ensure each care provider and client have necessary access to only pertinent information. Other access is available to the client upon request if it follows Patient Sortal’s security and protection standards. Instead of sending several requests to various health care providers and then organizing the information, clients are able to direct health care providers to send the records on an ongoing basis directly to Patient Sortal to store and organize for the client. In addition, Patient Sortal is able to transmit necessary health information between the client’s health care providers, so each provider can obtain the information it needs to treat the client on a continuing basis. During transmission and storage, all PHI under Patient Sorta l’s control is encrypted and unobtainable at all times by outside agencies and individuals without the proper right to the information. We manage our client’s information throughout the duration of their contract or with parameters of each contract. Patient Sortal will not transmit/disclose your information to any third party without your consent except as required by law.

Client Rights

It is important to note that the information that Patient Sortal receives and stores on behalf of clients belongs to the clients. Clients have the right to deny any or all information from being shared with Patient Sortal and the right to deny Patient Sortal from disclosing any or all information to identified third parties. Clients have the right to revoke consent previously given to Patient Sortal to disclose information to a third party, but such revocation of consent shall be applicable seventy-two hours after Patient Sortal receives notice that a client has revoked the consent to disclose. Clients have the right to request, in writing, all or any portion of their health information stored by Patient Sortal at any time. Patient Sortal will respond to client requests for information within thirty days of the request. Clients have the right to request that Patient Sortal discontinue Patient Sortal’s ability to receive information from the clients’ health care providers pursuant to the clients’ right of access, to end services with patient Sortal, and to receive a copy of all of the health information in their Partial Sortal file. At the time of termination of services, the client’s Patient Sortal file will be securely deleted from Patient Sortal’s database and Patient Sortal will no longer have access to any of the information.

Patient Sortal will only receive, manage, and transmit the health information of a child with the consent of a parent or other authorized legal representative.



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER ("SUD") PATIENT RECORDS BY PRIMECARE MEDICAL, INC.

Patient Name:_____ SSN:_____
Address:_____ Date of Birth: _____
_____

I hereby authorize **PrimeCare Medical, Inc.** at the _____(facility) to disclose the following information relevant to my treatment and case management plan (*initial*):

____ Course and results of treatment
____ Attendance in treatment
____ Substance use history
____ Diagnostic summary and diagnosis
____ Medical history / treatment
____ Drug / Alcohol test results
____ Biopsychosocial assessments
____ Evaluations and recommendations
____ Other: _____

____ Treatment plans
____ Disciplinary records
____ Legal history
____ Discharge summary
____ Social / Family history
____ Eligibility
____ Psychiatric Evaluation / Treatment
____ Verbal Exchange of information

To (*select one*):

_____ Individual(s): _____

_____ Entity **with** a treating provider relationship* (name and address of entity) _____
_____

_____ Entity **without** a treating provider relationship: To the following participants of
_____
[name and address of receiving entity]:
_____and/or
[name of individual participant(s) recipient in entity].
_____
[name of entity participant(s) in recipient entity, ***but only if the entity participant has a treating provider relationship*** with the patient].

Purpose(s) of disclosure [describe, be as specific as possible]: _____
_____
_____

* A "treating provider relationship" exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required for a treating provider relationship to exist.

I understand that my substance use disorder records are protected under federal law, including the

federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically one (1) year from the date that I sign it, or 30 days post-termination of services. I also understand that my revocation of this Authorization will not impact any action taken in reliance on this Authorization prior to PrimeCare's receipt of my written revocation.

I understand that my treatment may not be conditioned on my agreement to sign this Authorization. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the persons listed above and may no longer be protected.

I understand that I have the right to receive a list of entities to which my patient identifying Part 2 information has been disclosed; all requests must be submitted in writing. _____(initial)

I understand the nature of this Authorization. I have signed this Authorization

voluntarily. I understand I have the ability to obtain a copy of this form upon release.

_____ _____
Patient Signature *Date*

If the above signatory is a personal representative, their legal relationship to the patient/client is:

Signature of staff person obtaining authorization: _____
Staff name: _____

Date revoked: _____ **Staff initials:** _____

Notice to Recipient:
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

In addition to the above, the records from which this information has been disclosed are protected by other applicable Federal and State laws which prohibit you from making any further disclosure of this information unless expressly permitted by the written authorization of the patient or is otherwise permitted by law.

PRIMECARE MEDICAL, INC.
QUALITY CORRECTIONAL HEALTH CARE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ SSN: _____
Address: _____ Date of Birth: _____
_____

I hereby authorize **PrimeCare Medical, Inc.** at the _____ (facility) to release copies of the portions of my health records described below to _____, for the following purposes: _____
_____

Specific Information Covered by this Authorization

THE FOLLOWING INFORMATION IS SPECIALLY PROTECTED BY FEDERAL AND STATE LAWS. IF ANY OF THIS INFORMATION APPLIES TO YOU, PLEASE INDICATE ANY OR ALL OF THE INFORMATION YOU WOULD LIKE TO MAKE SUBJECT TO THIS AUTHORIZATION:

( ) Alcohol/Drug Abuse Records ***** Additional Form Required (H-RR2)*****
( ) Mental Health Records _____ *Initials*
( ) HIV Related Info. _____ *Initials*

( ) Discharge Summary ____ Initials
( ) History/Physical Info. ____ Initials
( ) Laboratory Studies ____ Initials
( ) X-ray Reports ____ Initials
( ) Operative Reports ____ Initials
( ) Pathology Reports ____ Initials

Date(s) of Service and/or medical Information specific to this request: _____
_____

This Authorization will expire one (1) year from the date that I sign it. I understand that I may revoke this Authorization, in writing, at any time. I also understand that my revocation of this Authorization will not impact any action taken in reliance on this Authorization prior to PrimeCare Medical's receipt of my written revocation.

I understand that my treatment may not be conditioned on my agreement to sign this Authorization. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the persons listed above and may no longer be protected.

I understand the nature of this Authorization.

_____ _____
Patient Signature *Date*

If the above signatory is a personal representative, their legal relationship to the patient/client is: _____
_____

Signature of staff person obtaining authorization: _____

If this Authorization authorizes the release of Mental Health Records or HIV-related information, the following statement must be included with the information being released:

This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws. These laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the patient to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.