INFORMED CONSENT for DIAGNOSIS and TREATMENT

This information (the "Consent") is intended for the purpose of obtaining Your permission and consent to receive telemedicine services, as well as to inform You about Our privacy practices.

Having a condition requiring medical care, or being responsible for an individual requiring medical care, the patient (referred to hereinafter as "***You***" or "***Your***") hereby consents to the diagnosis and provision of such care via videoconference or telephone (collectively a "***Communication Interface***" which enables a "***Telemedicine Consult***") in accordance with the terms that follow. You understand that the medical providers providing the Telemedicine Consult are *not* employed by **RELYMD** (hereinafter, "***Us***," "***Our***" or "***We***"), and that each medical provider will identify themselves at the beginning of every Telemedicine Consult. You further understand that You must be physically located in a state where the medical provider is licensed in order to initiate a Telemedicine Consult.

You acknowledge that the effectiveness of any Telemedicine Consult depends on Your full disclosure of Your medical history and symptoms to the medical provider, and that failure to do so could result in adverse drug reactions, allergic reactions, or other medical problems. You recognize that while a Telemedicine Consult provides the benefits of reduced waiting time and cost, and allows treatment at home or another location of my choosing, there are inherent limitations to this approach. For instance, You acknowledge that the medical provider will not be in the room with You to conduct a physical examination, that the Communication Interface may not give the medical provider the same information that would be available during an in-person examination, and that either these limitations, or others not otherwise stated herein, could affect the medical provider's assessment or diagnosis of a condition and recommended treatment. You understand that these limitations necessarily restrict the conditions that can be treated during a Telemedicine Consult, and that You may be referred to a primary care physician, a local emergency department, or some other medical facility prior to receiving any diagnosis or care.

You understand that if the medical provider does provide a diagnosis and treatment to You, You may still be encouraged to seek follow-up care from a primary care provider or a specialty physician. Further, You agree that in the event that You experience an adverse reaction to the treatment prescribed during the Telemedicine Consult that You will seek follow-up care from a primary care physician, or a local urgent care or emergency department. You understand that We do not assume responsibility for Your continued medical care or treatment beyond the Telemedicine Consult.

You understand that if You are seeking a Telemedicine Consult under the terms of an agreement that We have entered into with Your employer and/or with a group administrator who works on behalf of Your employer, the medical record created as a result of any Telemedicine Consult may be uploaded into a new or existing electronic medical record to which Your employer or the group administrator has access. You further understand that if You do not want information about Your Telemedicine Consult added to a medical record to which Your employer of the group administrator may have access, You need to contact privacy@relymd.com *before* You begin Your Telemedicine Consult in order to obtain access to an alternative Communication Interface.

You recognize that the successful completion of a Telemedicine Consult is reliant upon Your access to a computer or mobile device with uninterrupted connectivity to the internet (collectively, the "Technology Component(s)"). In the event that any Technology Component fails for You or for the medical provider, the Telemedicine Consult may be interrupted or terminated. In the event any Technology Component suffers disruption, You will need to attempt to re-establish the Communication Interface. If the Communication Interface cannot be re-established, You will call (855) 955-0948 and ask to speak directly with a medical provider.

You recognize that the Telemedicine Consult is not taking place in a medical office, and that, while the medical provider is conducting the Telemedicine Consult from a HIPAA-compliant secure location, You remain responsible for preserving Your personal privacy during the Telemedicine Consult. You acknowledge that Your privacy is not assured if You choose to participate in the Telemedicine Consult from a public location, in the presence of others, or while using Technology Components that belong to others.

Consent for Treatment and for the Release of Information

You authorize Us, as well as the medical provider, to obtain, use and release Your personal information, including medical information (hereinafter, collectively Your "***Personal Health Information***" or "***PHI***") for purposes of conducting the Telemedicine Consult or for obtaining payment therefor, for the purpose of research, or for any other legitimate purpose deemed necessary by Us. Your authorization enabling Us to obtain and use Your PHI does not impose a duty upon Us to do so.

Some of the entities and/or individuals who are allowed to share or receive Your PHI include, but are not limited to, the following:

1. Third-party insurance companies, managed care companies, Medicare, Medicaid, workers' compensation or other payors that You identify as possibly responsible for paying for the Telemedicine Consult;
2. Groups or their agents subject to the Assignment of Insurance Benefits section of this Consent;
3. Third-parties involved in processing applications for or determining Your eligibility for insurance coverage or other financial benefits, or compliance matters related thereto;
4. Third-parties who have referred You for a Telemedicine Consult, or to whom You are referred for other treatment, if any, including third-parties that are involved in determining any appropriate care for You before, during or after a hospital stay, or any physician and/or medical group practice that You designate during registration for the Telemedicine Consult;
5. Third-parties at Your home or other designated locations, or who connect the medical provider to You through any Communication Interface;
6. Third-parties that You represent are involved in Your care or whom You allow to be present when information is communicated to You; and,
7. Third-parties for the purpose of research, whether non-commercial or commercial in nature, where data related to You or Your care has been anonymized so that Your identity is not capable of being determined from the data.

You understand that You may request restrictions on disclosure of Your PHI by completing Our ***Request for Restriction of PHI*** form. You also understand that You may revoke this Consent by delivering a written notice of Your revocation to Us, except that actions which have already been taken based upon this Consent, including the disclosure of PHI to third-party payors to seek payment for the care and treatment provided to You, cannot be revoked. You also understand that PHI disclosed pursuant to this Consent may be subject to re-disclosure and would not be protected under the terms of any privacy law even if You were to subsequently revoke Consent.

By continuing with the Telemedicine Consult after being presented with this Consent You will have acknowledged that You have read this Consent form in full, that You understand Your rights and duties hereunder, and that You have hereby given Your informed consent for the medical care that You receive as it pertains to the Telemedicine Consult.

Our Pledge Regarding Your PHI

The protection and security of Your PHI is important to Us. This section of the Consent will further describe ways in which We may use and disclose Your PHI.

We are required by law to:

1. Give You this Consent setting forth Our legal duties, privacy practices, and Your rights regarding the PHI which We collect and maintain;
2. Maintain the privacy of Your PHI;
3. Notify You that We may use Your physical mailing address, email address(es), telephone number(s) and any other similar information that We may have in Our possession to communicate with You for any commercially-reasonable purposes via physical or digital means, including, but not limited to, by the sending of emails, text messages and telephone calls.
4. Notify You if We discover a breach of any of Your PHI that is not secured in accordance with federal or state law.

Your Rights Regarding Your PHI

You have the following rights with respect to Your PHI:

1. **Right to Inspect and Copy:** You have the right to inspect and copy all or any part of Your medical or health record, as provided by state and federal regulations. You may request and receive an electronic copy of Your PHI if We maintain Your PHI in an electronic health record. To inspect and copy Your PHI, You must submit Your request in writing to Our Privacy Officer at the physical address listed at the end of this Consent. If You request a copy of Your PHI We may charge a reasonable, cost-based fee associated with fulfilling Your request. We may also deny Your request under certain limited circumstances.
2. **Right to Amend**: You have the right to request that We amend Your PHI or a medical or health record about You if You feel that the health information We have about You is inaccurate or incomplete. You have the right to request an amendment for as long as We keep the information. To request an amendment, Your request must be made in writing, submitted to Our Privacy Officer at the physical address listed at the end of this Consent, and must include a reason that supports Your request. We may also deny Your request under certain limited circumstances.
3. **Right to an Accounting of Disclosures:** You have the right to request an accounting of any disclosures of Your PHI that We have made, except for disclosures made for the purpose of treatment, payment, health care operations and certain other purposes if such disclosures were made through a paper record or other health record that is not electronic, as set forth in state and federal regulations. If You request an accounting of disclosures of Your PHI, the accounting may include disclosures made for the purpose of treatment, payment and health care operations to the extent that disclosures are made through an electronic health record.

   To request an accounting of disclosures, You must submit Your request in writing to Our Privacy Officer at the physical address listed at the end of this Consent. Your request must identify a time period that does not span longer than six (6) years from Our date of receipt of Your written request. The first accounting You request will be free. For additional requests for an accounting occurring within twelve (12) months of the original request, We may charge You for the costs related to Our response but We will first You of the cost involved, after which You may choose to withdraw or modify Your request before You incur any costs.
4. **Right to Request Restrictions:** You have the right to request a restriction or limitation on the use and disclosure of Your PHI. You also have the right to request a restriction or limitation on the disclosure of Your PHI to someone who is involved in Your care or the payment for Your care, such as a family member or insurance company. For example, You could ask that We not disclose information to Your spouse about a medical service You received. You may request that We communicate with You only by a specific method, for example, by specifying that we only contact you by text message or by telephone call, and not through email. If You pay for the Telemedicine Consult entirely out-of-pocket, You may request that information regarding the Telemedicine Consult be withheld and not provided to a third-party payor, and We are obligated by law to abide by this request.

   To request a restriction on the use and disclosure of Your PHI, or on the method by which we communicate with You, You must make Your request in writing to Our Privacy Officer at the physical address listed at the end of this Consent. In Your written request, You must tell us what information You want to limit and to whom You want the limitations to apply. We will notify You of Our decision regarding the requested restriction. If We do agree to Your requested restriction, We will comply with Your written request unless the information is needed for some other legitimate purpose otherwise set forth in this Consent.
5. **Right to Receive Confidential Communications:** You have the right to request in writing that We communicate with You about Your PHI in a certain way or have such communications addressed to a certain location, but any such request must be deemed reasonable in nature. For example, You can request that We only contact You at work or by mail to a specified post office box. To request confidential communications, You must make Your request in writing to Our Privacy Officer at the physical address listed at the end of this Consent. Your written request must specify how or where You wish to be contacted.
6. **Right to a Paper Copy of this Consent:** You have the right to obtain a paper copy of this Consent at any time upon request. To obtain a paper copy of this Consent, please request it via email at privacy@relymd.com, or sending a written request to Our Privacy Officer at the physical address listed on the last page of this Consent.

7. **Right to Revoke Authorization:** If You execute any authorization(s) for the use and disclosure of Your PHI, You have the right to revoke such authorization(s) on a going forward basis. Revocation cannot change actions that have already been taken in reliance on such authorization.

How We May Use and Disclose Your PHI Without Your Authorization

The following categories describe different ways that We may use and disclose Your PHI without Your authorization.

1. **For Treatment:** We may use Your PHI while providing You with health care treatment or services. We may disclose Your PHI to other doctors, nurses, technicians, health students, or other personnel who are involved in taking care of You. For example, another doctor treating You for a broken leg may need to know if You have diabetes because diabetes may slow the healing process.
2. **For Payment:** We may use and disclose Your PHI so that the treatment and services You receive from Us may be billed to and payment collected from You, an insurance company, or a third-party. For example, We may need to give Your health plan information about services You received from the medical provider so that Your health plan will pay Us or reimburse You for the Telemedicine Consult. We may also tell Your health plan about a treatment You are going to receive to obtain prior approval or to determine whether Your insurance plan will cover the treatment.
3. **For Health Care Operations:** We may use and disclose Your PHI for healthcare operations. For example, We may use Your PHI to review Our treatment and services and to evaluate the performance of the medical providers who conduct the Telemedicine Consult.
4. **For Research:** We may disclose Your PHI for the purpose of research, whether commercial or non-commercial in nature, subject to the conditions noted herein. We will only disclose Your non-anonymized PHI for research purposes if the research protocol has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of Your PHI. The restrictions stated herein do not apply to instances where data related to You or Your care has been anonymized so that Your identity is not capable of being determined from the data.
5. **As Required By Law:** We may disclose Your PHI when required to do so by federal, state, or local law.
6. **To Avert a Serious Threat to Health or Safety:** We may use and disclose Your PHI when necessary to prevent a serious threat to Your health and safety, or the health and safety of the public or another person.
7. **Military and Veterans:** If You are a member of the armed forces or separated/discharged from military services, We may release Your PHI as required by military command authorities or by the Department of Veterans Affairs, as may be applicable. We may also release PHI about foreign military personnel to the appropriate foreign military authorities.
8. **Workers' Compensation:** We may release Your PHI as authorized by, and in compliance with, laws related to workers' compensation and similar programs established by law that provide benefits for work-related illnesses and injuries without regard to fault.
9. **Public or Private Health Activities:** We may disclose Your PHI for public or private health activities. These activities generally include the following:
    - to prevent or control disease, injury, or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify third-parties required to receive information on FDA-regulated products; and,
    - to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease or condition.
10. **Health Oversight Activities**: We may disclose Your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

11. **Lawsuits and Disputes:** If You are involved in a lawsuit or a dispute, We may disclose Your PHI in response to a court or administrative order. We may also disclose Your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell You about the request or to obtain a legal order protecting the information requested.
12. **Law Enforcement:** We may disclose Your PHI to law enforcement officials for law enforcement purposes including the following:
    - in reporting certain injuries, as required by law, such as gunshot wounds, burns or injuries to actual or suspected perpetrators of crime;
    - in response to a court order, subpoena, warrant, summons or similar legal process;
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - in reporting about the victim of a crime, if the victim agrees to disclose, or if the victim is rendered incapable of agreeing to disclose by virtue of their medical condition;
    - in reporting about a death We believe may be the result of criminal conduct;
    - in reporting about actual or suspected criminal conduct, crime location, crime victim
13. **Organ and Tissue Donation:** We may disclose Your PHI to organizations involved in the procurement, banking, or transplantation of cadaveric organs, eyes or tissue, for the purpose of facilitating organ and tissue donation.
14. **Abuse, Neglect and Domestic Violence**: We may disclose Your PHI to an appropriate governmental authority if We reasonably believe that You may be a victim of abuse, neglect, or domestic violence. We will only make this disclosure if You agree or when required or authorized by law.
15. **Coroners, Health Examiners and Funeral Directors:** We may disclose Your PHI to a coroner, health examiner or funeral director in order to identify a deceased person or determine the cause of death.
16. **National Security and Intelligence Activities:** We may disclose Your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, or for the purpose of providing protective services to the President or foreign heads of state.
17. **Inmates:** If You are an inmate of a correctional institution or under the custody of a law enforcement official, We may disclose Your PHI to the correctional institution or law enforcement official. This disclosure would be necessary: (a) for the correctional institution to provide You with medical care; (b) to protect Your health and safety, or the health and safety of others; or, (c) for the safety and security of the correctional institution.

We May Not Use or Disclose Your PHI for the Following Purposes without Your Authorization

1. We must obtain an authorization from You to use or disclose psychotherapy notes unless it is for treatment, payment or health care operations, or is required by law, permitted by health oversight activities, to a coroner or medical examiner, or to prevent a serious threat to health or safety.
2. We must obtain an authorization for any use or disclosure of Your PHI for any marketing communications to You about a product or service that encourages You to use or purchase the product or service unless the communication is either; (a) a face-to-face communication, or; (b) a promotional gift of nominal value. However, We do not need to obtain an authorization from You to provide prescription refill reminders, information regarding Your course of treatment, case management or care coordination, to describe health-related products or services that We provide, or to contact You in regard to treatment alternatives.
3. We must obtain an authorization for any disclosure of Your PHI which constitutes a sale of PHI, unless the information disclosed which relates to You or Your care has been anonymized so that Your identity is not capable of being determined from the data.
4. **We must obtain an authorization for all other uses and disclosures of Your PHI not otherwise described in this Consent. If You provide Us with written authorization to use or disclose Your PHI, You may revoke that authorization, in writing, at any time, by addressing a letter to Our Privacy Officer at the physical address listed at the end of this Consent.**

Your Assignment of Insurance Benefits and Guaranty of Payment

You understand that You are required to make the full payment of any medically-necessary charge, co-payment or deductible due at the time of Telemedicine Consult. You represent that the information that You give to Us, for any purpose, including, but not limited to, for the purpose of enabling Us to bill any third-party payor, is truthful, correct and accurate. You hereby authorize us to bill any third-party payor, including medical insurance payors, for the Telemedicine Consult or any other services that we provide. Further, You hereby authorize payment of insurance or other third-party benefits directly to Us.

You recognize that a Telemedicine Consult is not always covered by applicable governmental benefits (Medicare/Medicaid) or other third-party insurance. You understand that You are financially responsible for, agree to pay and guarantee payment in full of, any and all charges for the Telemedicine Consult. You understand that a bill for any unpaid portion of the Telemedicine Consult will be sent to Your address on file unless You complete a request for the bill to be sent to an alternate address.

In the event that You do have third-party insurance coverage for the Telemedicine Consult, You authorize Us to act as attorney-in-fact to act on Your behalf with regard to: (1) collect benefits from any responsible third-party through whatever commercially-reasonable means are necessary; and, (2) endorsement of benefit checks made payable to You for services provided by Us, including, but not limited to, for the Telemedicine Consult. If collection efforts are needed to obtain payment from You for the Telemedicine Consult, You agree to pay the cost of such collection efforts, including reasonable attorneys' fees.

You authorize Us to pay any refund that is due as the result of any overpaid insurance benefits to the appropriate third-party payor in accordance with Your insurance policy conditions or other applicable benefit provisions where Your coverage is subject to a coordination-of-benefits clause. With regard to any refund due to You, You authorize the immediate application of any such refund to any amount that You are personally legally obligated to pay for our services, including any Telemedicine Consult conducted by a medical provider. You understand that any remaining credit due after payment of these outstanding amounts will be refunded to You.

Changes to this Consent

We reserve the right to change Our privacy practices and any terms of this Consent. If Our privacy practices materially change, We will revise this Consent and make paper copies of the revised Consent available upon request. We reserve the right to make any revised version of this Consent effective for any of Your PHI which We already have in Our custody, as well as for any of Your PHI We receive thereafter.

To Make a Complaint

If You believe Your privacy rights have been violated, You may file a complaint with Us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Us, send a written notice of Your concerns to Our Privacy Officer at the physical address listed below. There will be no retaliation against You for filing a complaint.

If You have any questions about this Consent or if You should need further information, please contact Our Privacy Officer by telephone at (855) 955-0948, or by email to privacy@relymd.com . Written requests should be addressed to:

RelyMD, LLC
Attn: Privacy Officer
4819 Emperor Boulevard
Suite 400
Durham, NC 27703